Federation of American Hospitals®

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The Honorable Patty Murray
Chair
Senate HELP Committee
154 Russell Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Senate HELP Committee
217 Russell Senate Office Building
Washington, DC 20510

Dear Chair Murray and Ranking Member Burr:

Thank you for your continued bipartisan leadership and support as we work to plan beyond the COVID-19 public health emergency (PHE or pandemic) and prepare for future PHEs. The Federation of American Hospitals (FAH) and our members appreciate your efforts in releasing the draft legislation, the *Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act* (PREVENT Pandemics Act). We welcome the opportunity to provide recommendations for this bipartisan legislation to address future PHEs based on lessons learned from COVID-19 and previous experiences in pandemic planning and response.

The FAH is the national representative of more than 1,000 tax-paying community 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 areas across 46 states, plus Washington, DC and Puerto Rico. Our members include 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.

COVID-19 has required our member hospitals, and their health care providers and staff, to exercise their preparedness and response capabilities on an unprecedented scale. The health care sector can and must leverage lessons learned to ensure greater capabilities and response strategies for future outbreaks. Hospitals are on the frontlines 24/7 and provide around-the-clock care to communities during both natural and man-made disasters. Because of this, as noted in the press release for this legislation, the nation's public health system, as well as our health care workforce, has been put to the test time and time again as we now enter the third year of the

COVID-19 PHE. We look forward to promoting policy solutions like those in the PREVENT Pandemics Act to ensure patients have continuous access to quality care during future PHEs and help ease the impact on frontline workers.

In considering provisions in the PREVENT Pandemics Act, we provide both general and specific recommendations for consideration based on the experiences of our member hospitals and look forward to continuing this important dialogue with the Senate HELP Committee.

General Pandemic Preparedness and Response Feedback:

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 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, nor 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 appreciates 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 Payments Program in the *Coronavirus Aid, Relief, and Economic Security (CARES) Act*.

Notably, 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 PHEs and other emergencies.

Another example is that tax-paying hospitals are excluded from eligibility for certain programs that would help combat future pandemics. The Federal Communications Commission (FCC) defines the eligibility criteria for its COVID-19 Telehealth Program such that tax-paying hospitals are ineligible for participation. Telehealth serves a critical role during pandemics and FAH member hospitals are often the sole provider of comprehensive medical care in their communities, especially in rural America.

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.

Enable Automatic Waivers by Making Permanent HHS Temporary Waiver Authority

The national impact of COVID-19 necessitated the development and issuance of 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 you as Congressional leaders to request that HHS work with stakeholders to identify those waivers that should be activated on a "blanket" waiver basis in response to future PHEs. Doing so will help ensure that health care providers do not waste precious time, energy, and resources identifying, requesting, and waiting for the waivers to be put in place.

PREVENT Pandemics Act Feedback:

TITLE I – STRENGTHENING FEDERAL AND STATE PREPAREDNESS

- Section 101. Comprehensive Review of the COVID-19 Response. The FAH strongly supports a non-political, comprehensive understanding of COVID-19 and response strategies. COVID-19 has and will continue to provide us with "lessons learned" in terms of preparedness and response, especially in terms of infectious diseases and pandemics.

- Section 103. Public Health and Medical Preparedness and Response Coordination. The FAH strongly supports the coordination between federal, state, local governments, and stakeholders. Coordination and preparedness will be the key to successfully navigating future pandemics.

  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 PHE preparedness and response programs through FY 2023. As such, the FAH urges Congress to maintain an ongoing, bipartisan dialogue regarding the necessity for these programs. We also urge Congress and the Administration to collaborate with health care leaders in crafting the next iteration of this legislation and 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 the leaders of the Senate HELP Committee, 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.

- Section 104. Strengthening Public Health Communication. The FAH supports the establishment of a Public Health Information Communication Advisory Committee to provide recommendations to the HHS Secretary on communication and dissemination of scientific and evidence-based public health information during PHEs. Misinformation

was amplified throughout the COVID-19 pandemic, which put Americans at greater risk and imposed an avoidable threat to the sustainability and functionality of the health care system.

We encourage collaboration of public health agencies, such as the CDC, with health care stakeholders so the health care community can provide input ensuring CDC guidance is relevant and actionable.

- Section 111. Improving State and Local Public Health Security. The FAH supports efforts to ensure coordination between health departments and other state agencies to improve preparedness and response planning. However, allowing for clinical judgment of medical professionals at the site of care is critically important when making decisions to broadly curtail care during a pandemic. Preparedness for a pandemic requires 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 example, 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 and the capacity of the local health system to provide needed care to the community. Instead, elective and non-urgent procedures, both those in an operating room and in other settings where the procedure can be safely performed, should be based on a case-by-case evaluation of many factors such as current and projected pandemic cases in the facility and in the surrounding area, supply of PPE, staffing availability and bed availability, urgency of the procedure, other patient factors, and clinical judgement.

- Section 112. Supporting Access to Mental Health and Substance Use Disorder Services during Public Health Emergencies. A positive development from the COVID-19 pandemic is the enhanced appreciation for the benefits of telehealth, particularly tele-mental health. To improve access to mental health and substance use disorder services, the Senate HELP Committee should continue to work to expand access to telehealth. This includes policies to remove arbitrary restrictions as to where a patient must be located in order to utilize telehealth services.

  Congress should finally repeal the Institutions for Mental Diseases (IMD) exclusion to improve access to needed treatment services for millions of Americans. The IMD exclusion has prohibited federal payments to states for services for adult Medicaid beneficiaries between the ages of 21 and 64 who are treated in facilities that have more than 16 beds, and that provide inpatient or residential behavioral health – SUD and mental illness – treatment. Repealing the IMD exclusion would greatly expand treatment

options for individuals suffering with SUD, which has only been exacerbated by the current COVID-19 pandemic.

The manner in which care is delivered via telehealth has changed substantially as a result of COVID-19 and waivers from the CMS. The telehealth flexibilities enacted during the COVID-19 PHE should remain for future pandemics because they expand access to services and support care delivery during the ongoing pandemic and beyond.

TITLE II – IMPROVING PUBLIC HEALTH PREPAREDNESS AND RESPONSE CAPACITY

- Section 201. Addressing Social Determinants of Health and Improving Health Outcomes. The FAH and its members are keenly aware of the undeniable health disparities uncovered by the COVID-19 PHE, including the increased rates of infections, complications, and death among Black, Hispanic, and Native Americans compared to White patients. We strongly agree that closing the health equity gap is an essential part of transitioning as a nation towards a value-based health care system. Addressing social determinants of health is a critical part of understanding health disparities since they exacerbate and can lead to inequitable care outcomes. While not directly "health care-related," food insecurity, homelessness, poverty, and poor education can dramatically harm health outcomes.

  Robust, accurate, stratified equity reporting could be facilitated by collecting a standardized set of social, psychological, and behavioral interoperable data elements by hospitals at the time of inpatient admission. Additional hospital resources would be necessary to create optimal conditions for a large set of sensitive data to be collected.

  Hospitals already often collect certain demographic data (e.g., date of birth) and some information that could link to certain social risk factors (e.g., place of residence). But current collection is quite variable, driven by demands from states, insurers, and public health agencies, amongst others. The FAH believes that standards and specifics for improved data collection on social determinants is needed for successful implementation in health programs to improve care and outcomes. Clearly defined and standardized data elements, specific methods of data submission and validation, and the additional costs of the associated collection burden must first be addressed.

  We urge you as Senate HELP leaders to advocate an incremental approach to better understand and collect data on social determinants of health developed through deliberate and transparent collaboration with hospitals, patient groups, and other stakeholders.

- Section 211. Modernizing Biosurveillance Capabilities and Infectious Disease Data Collection. The FAH supports provisions that increase abilities for entities to properly engage in disease surveillance. During the COVID-19 pandemic, despite the strain to the

health system, efforts to rapidly rally, share data, and collaborate among key stakeholders quickly coalesced. These types of collaborations were invaluable in detecting, identifying, modeling, and tracking infectious disease, yet substantial barriers inhibit their successful engagement by limiting information sharing, inhibiting trust regarding safeguards to intellectual property and data use, and limiting the resources that can be leveraged. We ask that the Senate HELP Committee consider the initiatives discussed below to facilitate information sharing and increase support to enable these collaboratives to succeed and strengthen our nation's surveillance activities.

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 with appropriate protections should be in place in order to protect an individual's data and foster the necessary trust between partners that render collaborations successful. The FAH supports 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.

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. 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.

- Section 221. Improving Recruitment and Retention of the Frontline Public Health Workforce. The FAH strongly supports significant federal investments in provider loan repayment programs, including the Nurse Corps, to incentivize caregivers to serve in rural and underserved communities. Among the greatest challenges facing hospitals today is maintaining a sustainable workforce, especially in the wake of historic burnout and resignations throughout the COVID-19 PHE. We urge Congress to prioritize measures to support frontline health care providers and maintain a robust workforce in both the short and long term.

TITLE IV – MODERNIZING AND STRENGTHENING THE SUPPLY CHAIN FOR VITAL MEDICAL PRODUCTS

- Section 401. Warm Base Manufacturing Capacity for Medical Countermeasures. The FAH supports additional regulation and funding that will ensure support of domestic manufacturing of essential medical countermeasures (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 supports Congress in encouraging 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.

- Section 402 - 410. Strategic National Stockpile Considerations. The FAH recommends that the Strategic National Stockpile (SNS) be redesigned to align with the national supply chain.

  The 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 ensure 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 global 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 recommends 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 end-to-end leaders 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. 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.

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The FAH and its members thank you for your leadership throughout the COVID-19 pandemic, and in proactively preparing for future pandemics. 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 PHEs. 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,