Charles N. Kahn III
President and CEO

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President-elect Joe Biden
COVID-19 Task Force
Washington, DC

Dear President-elect Biden:

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 offers our congratulations to President-elect Biden, Vice President-elect Harris, and the members of their transition team. The challenges facing your new Administration are unprecedented and we look forward to your determined and focused leadership.

First among these challenges is the urgent need to address the COVID-19 public health emergency (PHE). The past weeks have seen record-shattering rates of infection and rising hospitalizations throughout the country. This rising tide sparks renewed concerns about the American response to the virus even though better treatment and vaccines are on the horizon. It is mission critical that the pandemic be brought under control. **Therefore, at the outset, we urge immediate action to extend the PHE, which was last renewed for 90 days by the Secretary of the Department of Health and Human Services (HHS) on October 23, 2020. This renewal is paramount for hospitals to sustain efforts to meet COVID-19 as it surges into 2021.**

As hospitals and front-line providers who are battling this pandemic every day, we are encouraged by the comprehensive and coordinated approach you have outlined to address

COVID-19. **A centralized national mitigation and communications strategy, with early stakeholder engagement, will be paramount in helping hospitals provide the care patients need and a significant factor in helping hospitals timely receive the supplies and testing needed, as well as vaccines when they are available, along with maximizing appropriate and useful data reporting that can help mitigate COVID-19.**

It is equally important to have in place and set the example for actions that can control the spread of the virus. Clear and consistent guidelines on social distancing, masking, contact tracing, and isolation will be paramount to protecting public health and preventing hospitals from becoming overwhelmed. Surges in hospitalizations in recent weeks demonstrate that efforts to curb the transmission of COVID-19 have been insufficient. Public health officials know how to limit the spread of the pandemic, but largely due to mixed messaging regarding the importance of complying with expert guidance and a common misunderstanding of the virus' severity the virus has gotten the better of us. The most effective way to prevent COVID-19 hospitalizations and deaths is to prevent, or at least limit the spread of, the virus in the first place.

Unfortunately, America's splintered response to the pandemic to date has had mixed results, while COVID-19 rages out of control. **However, going forward it will be crucial to keep in place for the duration of the PHE some of the foundational steps that Congress and the current Administration have taken over the past eight months to provide support to individuals, states, businesses, and health care providers.**

For example, the EMTALA waiver allows hospitals to better screen patients at an offsite location which helps prevent the spread of COVID-19. Many other key waivers implement important flexibilities, for example, they: allow hospitals to treat outpatients at home through virtual technology; expand the types of practitioners and facilities, such as rural health clinics, that can treat patients remotely; allow evaluation and management services and behavioral health counseling and educational services to be provided on an audio-only (telephone) basis; and waive the inpatient rehabilitation facility (IRF) "60 percent" and "3-hour" rules, as well as the long-term care hospital (LTCH) "25-day" rule, which not only increases access to IRF and LTCH services during the pandemic, but because they are licensed and regulated as hospitals, IRFs and LTCHs are uniquely positioned to support overwhelmed front-line acute care hospitals.

All of the waivers, while too numerous to list here, have been critical for allowing hospitals to prepare for patient surge and care for patients throughout the PHE, while also protecting them from risk of exposure to COVID-19.

In addition, we need to maintain the public and private partnerships among health systems and governments, both local and federal, for launching initiatives to battle COVID-19, such as the Dynamic Ventilator Reserve, federal drug allocation strategies, and regular communications with stakeholders, including early notifications of expected Emergency Use Authorization (EUA) approvals, weekly updates through listening sessions and office hours that

allow for stakeholder outreach, and transparency of distribution schedules such as those we have seen with Remdesivir and Bamlanivimab.

We further encourage the new Administration to keep in mind the crucial role of non-COVID-19 related health care to the ongoing wellbeing of the communities we serve. Broad mandates to cease "elective," scheduled procedures, have left many patients unattended to and frankly contributed to the sense that patients with non-COVID emergencies should avoid seeking care. Additionally, these mandates inhibited necessary care, such as cancer screenings and non-emergent surgical procedures, further placing vulnerable Americans at risk. So, it is critical that COVID-19 policies, to the extent feasible, do not cause delays in ongoing and essential care, including diagnostics and procedures or preventive care where undiagnosed conditions or lack of follow up care may result in adverse outcomes for many patients.

While the FAH and our members deeply appreciate all of the support provided thus far to enable hospitals to care for their patients and communities during these extraordinary times, more needs to be done. For example, COVID-19 has caused businesses in many sectors to experience massive economic decline, disruption, and closure. This has resulted in loss of health insurance coverage for millions of individuals across the country, or the fear of such loss in the near future, as the COVID-19 continues its destructive path. **With the stress of job loss and COVID-19 looming, this is no time for Americans to worry about access to health insurance, and significant action can be undertaken to provide assurance of access to coverage.**

In addition to these critical policies, we urge the incoming Administration to take steps to support our country's health system so that hospitals and other health care providers have the resources they need to keep providing care 24/7 even when they have reached and exceeded full capacity in caring for the burgeoning influx of COVID-19 patients. To that end, we commend and appreciate the resources made available thus far by Congress and the Administration to ensure that hospitals have adequate resources to care for patients. For example, creation of the Provider Relief Fund (PRF), expanding access to and improving the repayment terms of the Medicare Accelerated and Advance Payment Programs, and announcing removal of the potentially devastating Medicaid Fiscal Accountability Proposed Rule (MFAR) from the regulatory agenda, have been essential for hospitals' efforts to combat COVID-19.

Going forward, there are many policies that have not yet been enacted or adopted that would dramatically improve the ability and capacity of America's hospitals to fight the COVID-19 pandemic.

As you finalize your COVID-19 response plan, we strongly encourage consideration of the policies and recommendations outlined below related to: (1) public/private partner operational strategy; (2) health care coverage; and (3) health system resources.

PUBLIC/PRIVATE PARTNER OPERATIONAL STRATEGY

Establish a Centralized Mitigation and Communication Strategy and Early Stakeholder Engagement

Establish a National Mitigation Approach

As discussed above, it is mission critical to develop a centralized national mitigation and communications strategy, with early stakeholder engagement. Many aspects of the COVID-19 mitigation strategy have been left to the states and their public health departments to manage. This includes hospital and lab reporting, therapeutics distribution and, more recently, the vaccine effort, which has been relegated to 64 jurisdictional micro plans. While a jurisdictional-based approach works well for geographically isolated incidents, it creates unnecessary complexity in the face of a national-level pandemic. Jurisdictional insights into vital and unique aspects of their populations need to be considered when developing plans, and specific geographic differences accounted for. However, complete decentralization of the vaccine distribution has left hospitals and health systems grasping for vital information and needing to interface with and adapt to 64 distinct and non-standardized strategies. This is particularly burdensome to health systems that centrally manage distinct hospitals across multiple states as it breaks down their centralized efficiencies during a time when they are most needed. **The FAH urges development of a centralized approach that supports national-level standardizations and system-level reporting capabilities and distribution strategies while considering jurisdictional input as part of the overall strategy.**

Establish a Centralized and Consistent Federal Communications Strategy

A centralized strategy is important for achieving reliable and consistent information flow between the government entities and health system stakeholders related to COVID-19 initiatives and key statistical data.

Many efforts thus far have necessarily involved multiple agencies and task forces – and these efforts would be better served through a robust centralized communications strategy that can provide hospitals and health systems with consistent messaging, including access to key contacts at the appropriate agency to assist them. **The FAH recommends that the incoming Administration focus on development of such a centralized communications strategy across multiple agencies that can jointly contribute to mutual efforts through mechanisms, such as multi-agency and/or multi-stakeholder calls.** This approach also should apply to access to reliable and valid statistical COVID-19 data that maintains consistency over time and has been thoughtfully architected to support strategic planning.

Engage Hospitals and Health Systems Early

To set up our health care organizations and nation for success, it is vital that access to federal level information be available to stakeholders as initiatives are being developed. **Early stakeholder engagement in the early stages of planning and initiative design allows for realistic planning and implementation of solutions.**

Establish Strategies for Use of Personal Protective Equipment

As COVID-19 surges, imminent shortages of personal protective equipment (PPE) are expected. The current Centers for Disease Control and Prevention (CDC) and National Institute for Occupational Safety and Health (NIOSH) guidelines, while helpful, do not provide flexibility for the reprocessing and extended use of PPE necessary to address the reality of these looming shortages. **In order to avoid reaching "crisis standards," it would be appropriate to have some of the strategies, such as reuse and reprocessing, available at the "contingency" level.**

Ensure Supply Chain Diversification and Reliability

The FAH supports increasing supply chain diversification by leveraging the global nature of the supply chain to build redundancies, while maintaining critical domestic capabilities. Overreliance on particular geographic locations, more critically, non-domestic locations, for supplies needed to address COVID-19 can lead to disruptions in the supply chain.

The United States has a robust supply chain with well-established rigor, discipline, and processes established over many years. However, to ensure that the supply chain is not broken, we must avoid single international supply sources. Both domestic and global manufacturing and sourcing capabilities are necessary to ensure multiple suppliers and facilitate scale up of production as necessary.

Further, well-established supply chain mechanisms and expertise need to be retained and leveraged when addressing shortages of critically-needed supplies. In the face of looming shortages, the FAH supports the creation of incentives for product manufacturers to stand up capacity domestically to address looming shortages coupled with the retention and leveraging of our country's well-established supply chain mechanisms, infrastructure, and expertise.

Provide Transparency and Update Resupply Processes of the Strategic National Stockpile

The FAH urges the incoming Biden Administration to increase transparency of the contents of the strategic national stockpile (SNS) as well as the mechanics and process to request supplies from it, and criteria to access it. In addition, when replenishing the stockpile, particularly in the midst of spikes in demand, existing national capacity should not be disrupted as this leaves hospitals and health systems scrambling for supplies that had been allocated to them and on which they were relying to treat their expected patient caseload. Health systems and hospitals then are relegated to finding alternative manufacturers to augment the reduced supplies they receive to address the disruption to patient care created by the re-allocation of supplies to the stockpile.

Refine Hospital and Lab Data Reporting Requirements

The FAH and its member hospitals support reporting, collecting, and analyzing national-level COVID-19 data necessary to mitigate the effects of the spread and impact of COVID-19 on patients, health care workers, and the general public. **We further support and commend the**

creation of a national "pandemic dashboard" under the Biden Administration and offer the recommendations below regarding hospital reporting as the dashboard is developed.

Rescind Hospital Data Reporting Condition of Participation

Effective September 2, 2020, the Centers for Medicare & Medicaid Services (CMS) introduced a new condition of participation (CoP) tied to data reporting, which is unnecessary and inappropriate. The CoP undermines the successful and ongoing collaboration hospitals have had with CMS and unnecessarily puts patients at risk if a hospital were forced to close for being unable to submit data, especially for reasons beyond the hospital's control. **While we support appropriate hospital data reporting, we urge the new Administration to rescind the data reporting CoP.**

Minimize Unnecessary Disruption of What Is Working

Because the COVID-19 PHE has been ongoing for most of 2020, hospitals have already undertaken substantial investment and deployed considerable resources to establish the technology and workflow processes necessary for meeting data reporting requirements and guidelines set forth by the current Administration. **We urge the new Administration to consider the disruption that hospitals and health systems would incur if certain processes are revised. For example, the current COVID-19 hospital reporting process through TeleTracking has taken approximately eight months to fine-tune into a reliable process that our hospitals and health systems are accustomed to and for which they have invested substantial resources to incorporate into their workflows. Any changes to this or any other system would need to be initiated with substantial notice to hospitals that allows them to incorporate the changes into their workflow.**

Further, adoption of and changes to data elements, template changes, and other requirements tied to hospital data collection and reporting efforts must consider the potential burden placed on hospitals, seek to minimize such burden, and also allow enough lead time for hospitals and health systems to develop and incorporate processes into their systems as necessary.

Support Enterprise-Level Data Reporting Solutions and Avoid Relying on States as Intermediaries

Development of an enterprise-level solution that supports centralized reporting for laboratories, such as the AIMS platform or TeleTracking (as currently exists for hospital reporting), is essential for promoting more efficient, accurate, timely, and increased hospital data reporting.

The addition of states as intermediaries adds complexity to the data submission pipeline and increases the risk of error. For COVID-19 hospital reporting, this resulted in having hospitals submit data to states that was never received by HHS. **To this end, we urge that providing enterprise-level, centralized, and standardized data submission capabilities be designed**

into all data collection efforts and allow states to act as an intermediary as a secondary option.

Ensure Proper Subject Matter Expertise

The organization or agency responsible for collecting hospital COVID-19 data must have the proper subject matter expertise in the necessary areas to ensure that hospitals receive: the necessary clarity with respect to the utility of data being requested; clarity and consistency of definitions and interpretations of data analysis; and the architecture of appropriate data systems that best support the necessary features for the intended goal of the data collection and associated technical support during use. Subject matter expertise should include, but not be limited to, data science, epidemiology, statistics, and enterprise level data management. **Facilitating access to subject matter experts is vital for successful, accurate, and consistent reporting.**

Ensure Transparency of Utility

The FAH urges the new Administration to be transparent with health care providers regarding the utility of data elements that are required for reporting related to COVID-19. This is particularly important when hospitals do not collect the data in the normal course of operations, or not at the requested frequency, and do not understand the ultimate use of the data that requires such extraordinary effort to report.

For example, beds and staff are not counted by hospitals daily. Staffing is projected ahead of time, and local determination of staffing needs per hospital is calculated weekly as a function of projections for adaptation to unexpected changes in patient volume, seasons, day of the week, and pre-determined thresholds identifying critical staffing needs. Yet daily bed and staffing counts are being requested for COVID-19 hospital reporting. If hospitals can manage their operations without daily bed counts, it is not clear what utility is provided by the daily collection of this data.

Provide Reporting Feedback

Any publicly reported data should first be shared with the appropriate hospital to address any errors. When data reporting requirements are put in place it is important for hospitals to be able to validate what they submit against what is received to ensure that no errors have been introduced in the submission process. The current COVID-19 hospital reporting effort only offers feedback (as of October) through public hospital-specific reports indicating reporting frequencies by hospital. While this provides the hospital reporting information, hospitals do not have an opportunity, prior to the reports being publicly disclosed, to correct any errors that occur during the data submission process. Public reporting without any opportunity for hospitals to validate the reports misinforms the public.

Address Health Inequities and Focus on Equitable Allocations of COVID-19 Therapeutics and Vaccines

The FAH urges the Biden Administration to focus on the long-standing systemic health and social inequities that have put minority groups at increased risk of contracting COVID-19 and dying from its complications. The FAH supports the use of federal allocation strategies for emerging therapeutics and vaccines available in limited quantities to ensure equity in access to novel and emerging treatments.

Further, the FAH supports the National Academy of Sciences, Engineering, and Medicine (NASEM) report, *A Framework for Equitable Allocation of Vaccine for the Novel Coronavirus,* for the thoughtful, evidence-based, and ethical considerations that have gone into structuring a national allocation strategy aimed at mitigating health inequities and disparities.

Finally, the FAH encourages the Biden Administration to define a standardized set of data elements that can be consistently reported or leveraged from current reporting efforts and used to identify inequities, such as those based on social status, race, ethnicity, and gender. Having a standardized data collection and reporting strategy will promote: accurate reporting to elucidate existing health and social inequities as it relates to COVID-19 and other health issues; national and local strategies aimed at eradicating or mitigating these inequities; and data to explore mechanisms for appropriate risk adjustment of quality measures and programs beyond the PHE.

Continued Need for Regulatory Flexibility to Ensure Access to Patient Care

CMS has issued more than 150 waivers and hundreds of frequently asked questions (FAQs) to afford much-needed regulatory flexibility and address provider questions. Over the last eight months, the agency has moved swiftly and thoughtfully in engaging providers to implement unprecedented bipartisan legislation and exercise existing authority, through numerous rounds of rulemaking and sub-regulatory guidance. Taken together, these policies have been critical in allowing hospitals to prepare for patient surges and continue to care for patients throughout the PHE, while also protecting their health care workforce from risk of exposure to COVID-19.

Hospitals rely heavily on these administrative flexibilities to meet the needs of COVID-19 and non-COVID-19 patients. Many of the waivers and legislatively mandated flexibilities have been transformational for our health care system in terms of utilizing technology to modernize and redesign how care is delivered. In fact, these new flexibilities and innovations have allowed hospitals to continue to provide patient-centered health care services conveniently to every facet of their community.

Now more than ever, with the latest surge in COVID-19 cases and hospitalizations, and as we enter the winter months, not only must we maintain these flexibilities, but we should explore additional waivers that facilitate a rapid and effective response. For example, existing waivers that permit the treatment of hospital outpatients at home through remote monitoring technology as well as many telehealth waivers have enabled hospitals and health systems to

continue to care for patients who lack access to transportation or for whom visiting the hospital could put them at risk. These and other waivers are critically important as we think about transitioning seamlessly to the "new normal" of care delivery.

The FAH supports efforts to transform certain temporary waivers into permanent Medicare policy and looks forward to working with the new Administration to achieve meaningful and lasting policy changes across our health care system. In some cases, Congressional action may be needed to ensure a smooth transition, and we urge the new Administration to work expeditiously with Congress to act on policies that require such action to become permanent Medicare policy.

We note that looking out on the horizon beyond the ongoing surge as well as the end of the PHE, we support efforts by the current CMS internal workgroup that is focusing on development of a "glide path" for phasing out temporary policies put into effect during the PHE, rather than a hard stop. It is necessary that hospitals and other health care providers have continued input into – and advance notice of – the phasing out of these waivers, including the eventual planned end of the PHE. Further, it is imperative that providers have a minimum of 45 days regarding any significant changes to allow planning and communication to patients and to ensure continuity of care for all patients.

Expand Access to Telehealth / Broadband

There has been unprecedented change in the use of telehealth to provide much needed access to health care services across the country during the PHE, for example, permitting remote patient monitoring for new or established patients with any single chronic or acute conditions; virtual check-ins and e-visits for new patients; audio-only evaluation and management services; and direct supervision via the virtual presence of a physician. The FAH appreciates the swift response by Congress and CMS to expand access to telehealth in response to this PHE, yet there is still more to do to ensure that the full potential of telehealth is harnessed so that patients have greater and more seamless access to the care they need.

The *Coronavirus Aid, Relief, and Economic Security (CARES Act)* gave the HHS Secretary the authority to waive certain requirements during the PHE, including allowing greater expansion of health care services provided via telehealth. Important *CARES Act* provisions include:

- Elimination of the geographic and originating site requirements. Providers may deliver telehealth services to patients in their homes and other locations and in any area of the country.
- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites for the provision of telehealth services.
- Allowing all health care professionals who are eligible to bill Medicare for their professional services (including physical therapists, occupational therapists, speech language pathologists, and others) to deliver and bill for services provided via telehealth.

- Elimination of the requirement that the health professional has treated the Medicare beneficiary in the past three years.

The FAH supports continued efforts to permanently remove the geographic and originating site requirements as well as efforts to remove barriers to access to telehealth services. More specifically, we urge the new Administration to work with Congress in advancing legislation including but not limited to:

- The *Protecting Access to Post-COVID-19 Telehealth Act*, which would continue the expanded use of telehealth beyond the COVID-19 pandemic by eliminating restrictions on its use in Medicare, providing a bridge for patients currently using the practices because of the crisis, and requiring a study on the use of telehealth during COVID-19.
- The *Temporary Reciprocity to Ensure Access to Treatment Act*, which would provide temporary licensing reciprocity for all practitioners, including those who treat both physical and mental health conditions, in all states for services (in-person and telehealth) during the COVID-19 response and for future PHEs.

In addition, we urge the new Administration to support additional funding for the Federal Communications Commission's (FCC) recently-launched COVID-19 Telehealth Program, while also expanding the program's eligibility criteria to ensure full participation from a broad number of health care stakeholders, including tax-paying hospitals. As currently defined by the FCC, the eligibility criteria for the COVID-19 Telehealth Program makes tax-paying hospitals ineligible for participation. This unjustly penalizes patients living in communities across the United States that are served by a tax-paying hospital and should be remedied by the incoming Administration.

HEALTH CARE COVERAGE

Ensure and Maintain Health Insurance Coverage

Individuals who may be infected with COVID-19 should not delay testing and/or accessing care due to concerns about potential costs or cost-sharing. While the current protections provided by Congress from cost-sharing related to COVID-19 testing are an important step, more certainty must be provided to patients regarding their ability to access treatment.

Using funds, including from the PRF, enacted as part of the *Families First Coronavirus Response Act (Families First Act),* the *Paycheck Protection Program and Health Care Enhancements Act (PPP Act)*, and *CARES Act*, HHS, through the Health Resources and Services Administration (HRSA)-administered COVID-19 Claims Reimbursement Fund, generally reimburses health care providers at Medicare rates for testing uninsured individuals for COVID-19, for treating uninsured individuals with a COVID-19 primary diagnosis, and for eventual COVID-19 vaccine administration to the uninsured.

The Reimbursement Fund includes $2 billion specifically earmarked by law to reimburse providers for COVID-19 testing for uninsured individuals. In addition, HHS is using PRF funds to reimburse providers for treating uninsured COVID-19 patients. As the pandemic surges and with the recent approval of an EUA for monoclonal antibody treatment for use in hospital outpatients with confirmed diagnosis of COVID-19 and vaccines available in 2021, **additional funding may be needed to ensure that the uninsured and underinsured have access to testing as well as these important treatments and preventive services at no cost. This is especially important because, as noted below, the PRF itself is in danger of depletion. The FAH urges the new Administration to work with Congress to ensure sufficient funding for the COVID-19 Claims Reimbursement Fund.**

Concerns regarding access to affordable health insurance coverage extend beyond conditions related directly to COVID-19. With unprecedented levels of unemployment, individuals and families are at risk of losing their employer sponsored coverage, with no viable means of affording COBRA or the premiums associated with coverage provided on the health insurance exchange. This loss of coverage could lead to the deferral of necessary care, increased enrollment in public health programs, and additional stress on hospitals as they shoulder the disproportionate share of uncompensated care.

We urge the new Administration to work with Congress to take all necessary steps to ensure Americans can maintain or gain access to affordable health insurance coverage, especially as it relates to Employer-Sponsored Insurance (ESI), including:

- Subsidies and/or tax credits to employers to partially offset the cost of continuing to provide ESI to their employees;
- Federal assistance to recently unemployed individuals to offset the full cost of their coverage through COBRA;
- A Special Enrollment Period for Federally Facilitated Exchanges to enable previously uninsured individuals to access affordable health coverage;
- Enhanced eligibility for subsidies on the Exchanges.

For already-insured individuals, Congress, at a minimum, should require that all insurance plans, including Short-Term Limited Duration Plans and Association Health Plans:

- Provide coverage for COVID-19-related testing, treatment, and post-acute treatment;
- Waive patient cost-sharing for COVID-19-related services and reimburse providers for the cost-sharing portion;
- Remove prior authorization requirements related to COVID-19 care to ensure patients receive timely services;
- Remove prior authorization requirements related to post-acute care to preserve inpatient hospital resources.

As mentioned previously, for those individuals who remain uninsured after implementation of the aforementioned policies, the FAH recommends that Congress provide a unique and specific funding allocation to cover the costs associated with

providing COVID-19-related treatment to uninsured individuals – similar to how such funding is provided for testing and testing related services via the *Families First Act*.

HEALTH SYSTEM RESOURCES

Extend the Medicare Sequestration Moratorium

In March, Congress suspended the Medicare sequestration cuts through the end of the 2020 calendar year under the *CARES Act.* Unfortunately, as discussed above, the COVID-19 pandemic is far from over – and is in fact worsening across the United States as we head into the winter months and overlap with the annual flu season**.** As we enter this next phase of the pandemic, medical professionals and health care facilities must have the resources necessary to: 1) safely prepare for increasing patient caseloads; 2) procure sufficient PPE and ensure adequate staffing; 3) prepare for vaccine storage and administration; and 4) provide quality treatment for an influx of COVID-19 patients, especially older and more vulnerable populations, as well as non-COVID-19 patients.

Now is not the time to re-impose Medicare sequestration cuts, which are scheduled to return on January 1, 2021, and put further strain on our caregivers and their ability to treat patients. **As such, the current moratorium on the sequestration cuts should be extended through the end of the COVID-19 PHE.**

Replenish and Ensure Flexibility of the Provider Relief Fund

The PRF has been critical in providing hospitals with the financial support needed to maintain their ability to provide vital services for patients and their communities. Yet the PRF, financed through $175 billion in funds appropriated under both the *CARES Act* and *PPP Act*, is now nearly depleted at the very moment that patient caseloads and hospitalizations reach new peaks daily, with no end in sight. To ensure both the short-term and long-term stability of the nation's hospitals and health care infrastructure, we need Congress to continue its bipartisan efforts to provide the resources necessary to keep our doors open for our patients and communities. The best way to do that is to replenish the PRF, ensure that it remains funded at a level that will sustain providers through the entirety of the PHE, and direct a significant percentage to hospitals for the reasons noted below.

The nation's hospitals and the nearly one million acute care beds they operate are disproportionately and profoundly burdened by the COVID-19 crisis, with many, particularly rural hospitals, struggling to financially weather the PHE. First, hospitals have made and continue to make significant investments to meet intensive and continually evolving clinical care requirements for COVID-19 patients. These capital costs include the acquisition of critical supplies and ventilators at increasing costs amid shortages, as well as altering the hospital's physical environment to expand critical care capacity, manage points of entry, and otherwise prepare for a surge in COVID-19 cases. They are incurred alongside significant labor costs as hospitals work to supplement front-line caregivers in order to adequately staff critical care areas and relieve over-burdened workers and workers who are quarantined after suspected exposure to COVID-19. Second, hospitals are absorbing sustained financial losses stemming from a

reduction in patients seeking non-emergent clinical care – including scheduled inpatient procedures, outpatient surgeries, and diagnostic procedures – as well as emergency room activity. Hospitals rely on these services not just to sustain a stable revenue base, but to help offset the cost to provide other essential health care services to the community. Third, hospitals are investing in testing, training, and other resources to maintain care for non-COVID-19 patients. Fourth, they have in many cases postponed critical investments in life-safety infrastructure and clinical services, which will have longer-term negative impacts. Hospitals, alone, have had to meet all four of these challenges simultaneously, and, going forward, must maintain capacity and resources to handle this latest, unrelenting surge.

In addition to replenishing the PRF and, in allocating those funds, better recognizing the unique position and needs of America's hospitals, hospitals must be given necessary flexibility to efficiently administer, and retain, funds in the best interests of all the patients they serve. Current guidance, for example, arbitrarily limits the ability of many hospital systems to redeploy funds among its hospitals to where they are needed, for example, where a new hotspot emerges. In addition, misguided rules regarding the calculation of a hospital's "lost revenue," a key statutory criterion for distributing PRF dollars, will force many hospitals to return a substantial portion of the funds they desperately need. There are simple solutions to these problems, which we urge the incoming Administration to quickly adopt and give hospitals the assurance they need.

Extend Medicare Diagnosis-Related Group Add-On Payment

COVID-19 hospital patients are significantly compromised, with many requiring intensive care, often with prolonged ventilation. The length of stay for COVID-19 patients is significantly longer than that of the typical hospital inpatient, and the daily resources consumed for these cases are significant. This is all especially true for Medicare patients. In addition, a higher percentage of COVID-19 patients are uninsured and underinsured as compared to the typical inpatient payer mix, which results in additional uncompensated care for hospitals during the PHE.

Recognizing the high costs of care for COVID-19 cases, under the *CARES Act* Congress provided acute care hospitals with an increase in payment for Medicare inpatients diagnosed with COVID-19 (through a diagnosis-related group (DRG) add-on payment). These increased payments have proven critical in helping hospitals meet the direct costs of care and sustain operations. While this payment add-on ends with the expiration of the PHE, patients diagnosed with COVID-19 will continue to present and be treated by hospitals well after the PHE, and these cases will continue to be unusually high cost. At the same time, Medicare hospital payments are deeply and chronically negative, falling far short of patient care costs and structurally ill-suited to dealing with COVID-19 cases during and after the PHE. **We urge the new Administration to support efforts to extend this supplementary COVID-19 payment for an indefinite period while hospitals work to stabilize and reduce costs consistent with a standard of high-quality care that reflects emerging clinical protocols and best practices.**

Provide COVID-19 Liability Protection for Health Care Professionals and Facilities

It is imperative that health care professionals and facilities (including hospitals) are supported with broad relief from the threat of legal challenges as they adopt an all-hands-on-deck approach in addressing, preparing for, and responding to the COVID-19 PHE.

Hospitals, health care professionals, and the facilities where they treat COVID-19 and other patients have experienced unprecedented conditions, such as severe shortages of medical supplies (e.g., PPE, ventilators), workforce shortages, delays of important elective surgeries, and insufficient information and/or changing guidance from federal, state, and local government officials.

As these conditions and the COVID-19 PHE continues to surge, health care professionals and facilities face the daunting threat of medical liability lawsuits. **We therefore urge the new Administration to work with Congress to provide liability protection for health care professionals and facilities, similar to some states, such as New York, for any injury or death alleged to have been sustained because of any acts or omissions undertaken in good faith while providing health care services in support of the nation's COVID-19 response.** Stronger or broader state liability protections should not be preempted, and vital protections for those who are victims of acts of gross negligence or willful misconduct should be maintained. Federal action is necessary to provide a uniform level of protection and avoid varying liability laws among states that would lead to unequal treatment of our frontline health care providers and facilities during this national crisis.

Refrain from Action on the Medicaid Fiscal Accountability Regulation

In November 2019, CMS issued the MFAR proposed rule, which sought to apply new parameters to how common Medicaid financing arrangements – such as provider taxes, intergovernmental transfers, and donations – would be evaluated and approved by CMS. In September 2020, CMS Administrator Seema Verma announced her intent to withdraw the proposed rule from the regulatory agenda following steadfast opposition to MFAR from a broad range of stakeholders (ranging from the provider community to bipartisan Governors and Members of Congress). **The FAH firmly opposes MFAR and urges the new Administration to refrain from pursuing any similar regulation.**

The Trump Administration's MFAR proposal threatened access to health care services and undermined Medicaid programs across the country. Had this regulation been implemented, the consequences included impeding access to Medicaid services, and threatening the fiscal health of states and of many health care providers. It could have resulted in an estimated reduction in federal Medicaid funding to states of $37 – $49 billion. Of that reduction, $23 – $31 billion would have come from reduced payments to hospitals.[1]

Rather than protecting states' ability to use the aforementioned sources of funds to provide adequate Medicaid care, services, and payments, the proposed rule aimed to limit or restrict states' flexibility to finance their share of Medicaid. MFAR likely would have forced

[1] Analysis provided by Manatt Health, 2020

states to raise taxes or cut their budgets, as well as harm Medicaid beneficiaries by potentially limiting access to providers or cutting their Medicaid programs.

Although the FAH supports CMS's goals of promoting transparency, the FAH opposes the proposed rule given the harm it would inflict on the neediest Americans and patients across the country. The magnitude of cuts to Medicaid imposed by this proposal would have had a detrimental impact on hospitals' ability to provide care.

Increase Federal Matching Assistance Program Funding

The FAH appreciates Congress moving quickly to provide a 6.2 percentage point Federal Matching Assistance Program (FMAP) increase in the *Families First Act* and making these funds available to states from January 1, 2020 through the quarter in which the PHE ends.

Not unlike the recession of 2008, declining state tax revenue will severely limit state financial resources, all while Medicaid enrollment will likely increase due to increased unemployment. The Kaiser Family Foundation estimates that by January 2021, nearly 17 million people will be eligible for Medicaid and roughly 6 million will be eligible for *Affordable Care Act* marketplace subsidies if they have not found employment by that time.

Given the magnitude of both the public health and economic crises the nation continues to face, state and local governments need more support to provide health care services to individuals and families. As part of a national approach to addressing the COVID-19 PHE, we urge prioritization of funding for state and local governments. **More specifically, we urge the new Administration to work with Congress to provide an additional FMAP increase of at least 5.8 percentage points, retroactive to January 1, 2020, and that remains until September 30, 2021, regardless of unemployment conditions.** After September 30, 2021, the 12 percent FMAP increase should not be reduced until the national unemployment rate falls below 5 percent. In addition, we request additional FMAP increases be determined based on the increase in a state's unemployment rate.

Health care is inextricably linked to economic recovery from the COVID-19 PHE. When someone loses their job, they often also lose employer-based health coverage and become uninsured. There is ample precedent for Congress acting during economic downturns to temporarily increase the FMAP, including increasing the FMAP by nearly 12 percentage points a decade ago.

IMPACT Act

The FAH further urges the new Administration to support an immediate refresh of the Unified Post-Acute Care (PAC) Prospective Payment System (PPS) mandate outlined in the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014*. The *IMPACT Act* mandated the design of a Unified PAC PPS for the four PAC settings, and included a timeline for the collection and reporting of substantial amounts of quality and patient data, followed by an eventual report from CMS to Congress on a technical PAC PPS prototype.

In the wake of the COVID-19 pandemic, along with the changing dynamics of post-acute health care in recent years, it is imperative that CMS thoroughly re-evaluate its utilization of certain data and further pilot the required PAC PPS prototype before submitting its report to Congress.

In further consideration of multiple missed deadlines, the FAH strongly urges the new Administration to direct that CMS outline its implementation plan and ensure that the unified payment prototype is based on post-pandemic data and lessons learned, and robustly tested and modeled by PAC providers in a real-world setting before it is presented to Congress.

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We appreciate your leadership, along with the Task Force, in responding to the COVID-19 PHE and look forward to working with the incoming Administration to address the significant concerns raised by the PHE so that hospitals are able to continue providing the best care possible to patients and their communities. If you have any questions or wish to speak further, please do not hesitate to reach out to me or a member of my staff at 202-624-1534.

Sincerely,