hfma
healthcare financial management association

April 14, 2020

The Honorable Mitch McConnell
Senate Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Charles Schumer
Senate Democratic Leader
United States Senate
Washington, D.C. 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin McCarthy
House Republican Leader
U.S. House of Representatives
Washington, D.C. 20515

Re: Measures to Sustain Healthcare Providers During the COVID-19 Pandemic

Dear Speaker Pelosi, Leader McConnell, Leader McCarthy, and Leader Schumer:

On behalf of the Healthcare Financial Management Association's (HFMA's) 53,000 members, I would like to thank you and your colleagues for the bold action you've taken to-date to help sustain healthcare providers – particularly economically vulnerable rural hospitals – as they have canceled elective procedures and incurred significant expenses to prepare for the COVID-19 pandemic and provide lifesaving care to those in their communities afflicted by this virus.

Among other actions, our members are deeply grateful for the provisions in the CARES Act to:

- Delay the Medicare sequester and Medicaid DSH cuts
- Increase payment for inpatient care for COVID-19 patients
- Expand Medicare's ability to advance payments to providers offering much needed liquidity to hospitals and health systems
- Appropriate $100 billion to the Public Health and Social Services Emergency Fund (PHSSEF) to reimburse healthcare providers for COVID-19 related expenses and lost revenue as a result of canceled elective procedures.

Given the magnitude of the pandemic and its unprecedented impact on hospitals, physicians and providers, we ask that you appropriate no less than an additional $200 billion to the PHSSEF as a next tranche of the

relief funding. Based on the multiple competing demands for funding from the PHSSEF, anticipated duration of the national health emergency, and increased cost of providing care to COVID-19 patients our members strongly believe the initial appropriation is insufficient to ensure the financial viability of hospitals – particularly rural hospitals.

HFMA's members appreciate the expeditious manner in which the first $30 billion tranche of funds from the PHSSEF were distributed. It is our understanding that a portion of the remaining $70 billion will be used to cover the cost of care for uninsured patients who are diagnosed with COVID-19[1]. It is estimated that covering cost of COVID-19 treatment for uninsured patients will require $14 to $42 billion from the funds appropriated to the PHSSEF[2]. While covering the cost of care for the uninsured who suffer from COVID-19 is necessary and our members support it, using funds from the PHSSEF will reduce the dollars allocated to stabilize the finances of hospitals, physician practices, and other providers.

As you are aware, the Centers for Medicare and Medicaid Service asked hospitals to cancel elective procedures to reduce the risk of community spread of COVID-19 and preserve scarce supplies of personal protective equipment[3]. Hospitals have overwhelmingly and unhesitatingly complied as many hospitals in areas of the country that have not yet experienced a surge in COVID-19 cases sit mostly idle. As a result, approximately 50% of hospital revenue is elective and has been postponed or deferred. In addition, our members report seeing a significant decrease in emergency room visits attributable to Americans sheltering in their homes. As a result, hospital revenues have decreased dramatically. Total revenues are down 40-60% with ER visits are down 25-30%, inpatient surgical volumes are down 30-50%, outpatient surgical volumes and procedures are down 50%+, and ambulatory surgery center procedures down 70%+[4].

Analysts at J.P. Morgan project the initial $100 billion appropriation will cover approximately two months of lost revenue for hospitals. Unfortunately, this is insufficient as these funds will also, rightly, be used to offset revenue losses related to COVID-19 for other provider types and provide coverage for those who are uninsured and require treatment for COVID-19. Depending on the duration of time CMS's guidance to cancel elective procedures remains in place, we estimate that *hospitals alone will lose between $125 to $150 billion[5] in revenue*. Additionally, based on JP Morgan's estimates of decreased revenue, we project that physician practices will lose between $84 and $99 billion in revenue as a result of the pandemic[6].

And this figure does not take into account the additional expenses associated with creating surge capacity or treating a COVID-19 patient. Many hospitals have responded to the urgent need to create additional ICU beds. Because of these heroic efforts, we have not experienced the need to ration care that, sadly, other countries have. However, it can cost as much as $45,000[7] per bed to convert a general acute bed to an ICU bed.

Having increased capacity is necessary, but not sufficient. Hospitals have also incurred significant expenses related to increased clinical staffing to actually deliver the lifesaving care to afflicted patients. Average weekly pay for temporary registered nurses has nearly doubled from $1,700 in January to more than $3,000

[1] https://www.bloomberg.com/news/articles/2020-04-02/pence-says-hospitals-to-be-paid-for-uninsured-covid-19-patients
[2] https://www.kff.org/uninsured/issue-brief/estimated-cost-of-treating-the-uninsured-hospitalized-with-covid-19/?
[3] CMS Guidance on Elective Procedures
[4] https://markets.jpmorgan.com/research/email/-2kpqn02/pQkXdmsMoWg6SlyWWueoWA/GPS-3313255-0
[5] HFMA Analysis assuming CMS guidance on elective procedures remains in place between 2.5 to 3 months.
[6] HFMA Estimate
[7] https://www.npr.org/sections/health-shots/2020/04/06/828108255/growing-costs-and-shrinking-revenues-squeeze-hospitals-as-they-brace-for-coronav?

in March[8]. And caring for COVID-19 patients (or suspected COVID-19 patients) has significantly increased the demand and use rate for personal protective equipment (PPE) given how communicable the disease is. In some hospitals with significant COVID-19 patient loads, our members have reported that PPE usage has increased six-fold. This has driven well documented shortages and commensurate increases in prices for PPE of all types. For example, HFMA's members' organizations spent approximately $.50 per N95 mask in January. Now it's not uncommon for members to report N95 masks selling for more than $5.00 per mask.

Given the significant increase in expenses, it's estimated that hospitals will lose approximately $1,200 per case[9]. This analysis includes the 20% increase in Medicare payments for inpatient discharges related to COVID-19. Epidemiologists at Harvard have projected that as many as 20.5 million Americans[10] could be hospitalized during the course of the pandemic which would result in a loss to hospitals of $24.6 billion[11].

Given that reimbursing hospitals alone for lost revenue and patient care expenses related to COVID-19 will require between $150 to $225 billion we believe the initial appropriation will be insufficient to provide the necessary financial stability to hospitals, physicians, other providers, and uninsured Americans stricken with COVID-19. HFMA's members are particularly concerned about rural hospitals.

Over the past 10 years, 120 rural health-care centers have closed[12]. According to recent analysis by Guidehouse, conducted using financial results prior to the COVID-19 pandemic, more than 350 rural hospitals across 40 states are at risk of closing. Those hospitals represent more than 222,350 annual discharges, 51,800 employees and $8.3 billion in total patient revenue[13].

If these hospitals are allowed to close as a result of the financial harm caused by the COVID-19 pandemic, not only will their communities lose their main economic engine, but they will be ill prepared to respond to future pandemics or disasters. The table below provides an estimate of the expenses incurred and revenue lost by hospitals, physician practices and other providers as they have immediately responded to the COVID-19 pandemic compared to what has currently been appropriated to the PHSSEF.

[8] https://www.modernhealthcare.com/providers/covid-19-poses-long-term-impact-not-profit-hospitals
[9] https://www.stratadecision.com/blog/report-hospitals-face-massive-losses-on-covid-19-cases-even-with-proposed-increase-in-federal-reimbursement/
[10] https://www.healthaffairs.org/do/10.1377/hblog20200317.457910/full/
[11] HFMA Analysis
[12] https://www.ivantageindex.com/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf?mod=article_inline
[13] https://guidehouse.com/insights/healthcare/2020/rural-hospital-sustainability-index

Table 1: Projected Near-Term Financial Impact on Hospitals, Physicians and Other Providers of COVID-19

	Lower Bound Estimate	Upper Bound Estimate
Elective Procedure Revenue Lost Due to Adherence to CMS Guidelines - Hospitals	125,000,000,000	155,000,000,000
Other Provider Lost Revenue Due to COVID-19	83,792,876,712	99,300,000,000
Loss on COVID-19 Cases - Hospitals	25,000,000,000	25,000,000,000
Cost of Covering Care for Uninsured COVID-19 Patients	14,000,000,000	42,000,000,000
Total Relief Funds Required	247,792,876,712	321,300,000,000
Current PHSSEF Appropriation	(100,000,000,000)	(100,000,000,000)
Additional PHSSEF Appropriation Required	**147,792,876,712**	**221,300,000,000**

Therefore, we ask that Congress protect the American people by increasing the appropriation to the PHSSEF to reimburse hospitals, physician practices, and other provider types for near term revenue losses and expenses incurred as a result of the COVID-19 pandemic by at least $200 billion.

We also ask Congress to clarify the extent to which section 502 from the FY 2020 Consolidated Appropriation applies to the COVID-19 relief funds allocated to the Public Health and Social Services Emergency Fund. The Department of Health and Human Services Relief Fund Payment Terms and Conditions[14] references section 502 as follows:

> *SEC. 202. Executive Pay. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.*

For 2020 the compensation for Executive Level II federal employees is $197,300[15]. First, we ask Congress to clarify in statute that hospitals and health systems can pay individuals in excess of this amount using their own funds (not from the PHSSEF). As you are aware, most health systems employ a wide range of physicians and clinicians. As an example, hospitalist salaries range from $229,500 (25th percentile) to $313,500 (75th percentile) which reflects the years of education and training it requires to become a physician or clinician. It is not practical to cap compensation for clinical staff at an Executive Level II rate and have a functioning hospital that is appropriately staffed. We note that the Veterans Administration is not limited by the Federal Executive Compensation Schedule as it must pay market rates for clinical talent that provides care to our nation's veterans. We ask that Congress confirm that providers who accept PHSSEF funds have this same flexibility to pay market rates for clinical talent to provide care to our nation's citizens.

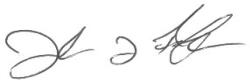
Second, given the increases in overtime and hazard pay for employed clinicians and the premium rates demanded by temporary staffing agencies who are providing additional clinicians to support surge capacity, we ask Congress to clarify in statute that recipients of funds from the PHSSEF can use the proceeds of those

[14] https://www.hhs.gov/sites/default/files/relief-fund-payment-terms-and-conditions-04092020.pdf
[15] https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/pdf/2020/EX.pdf

funds to pay for salaries, including those that are commensurate with or exceed the Executive Level II rate, of those individuals who spend the majority of their time responding to the COVID-19 pandemic.

HFMA looks forward to any opportunity to provide additional assistance or comments to support Congress's response to the COVID-19 pandemic. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, federal agencies and advisory groups. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

cc:
Alexander Azar, Secretary of Health and Human Services
Seema Verma, Administrator, Centers for Medicare & Medicaid Services

About HFMA

HFMA is the nation's leading membership organization for more than 53,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.