

April 1, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Priorities for the \$100 Billion Provider Relief Fund Created by the CARES Act

Dear Secretary Azar:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for your continued efforts to combat the Coronavirus Disease 2019 (COVID-19) outbreak caused by the SARS-CoV-2 virus and to offer additional assistance and recommendations in regard to the recent passage of the “Coronavirus Aid, Relief, and Economic Security Act,” (CARES Act) and its creation of the \$100 billion Provider Relief Fund¹ (Fund) to prevent, prepare for, and respond to the novel coronavirus.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 155 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The COVID pandemic is posing enormous challenges and tremendous stress on our entire health care system. We are grateful for the resources Congress has invested in the new Fund to address these challenges. The unprecedented scope and exponential growth of this pandemic, however, already demonstrates that the Fund’s current funding level will be insufficient to adequately support the current and future needs of hospitals and physicians, to say nothing of other engaged providers. Thus, we are recommending the following criteria to help prioritize the distribution of funds, as we commit to working with the Administration and Congress to provide increased resources to address the health care system’s growing needs in order to serve the public.

Our member teaching hospitals and physicians have risen to the call to be on the front lines of this crisis and are experiencing significant financial burden as a result. As the Department of Health and Human Services (HHS) makes Fund disbursement decisions, we urge you to proceed expeditiously to equip major teaching hospitals and faculty physicians across the country with

¹ Coronavirus Aid, Relief, and Economic Security Act or CARES Act, P.L. 116-136, 116th Cong., Division B Emergency Appropriations for Coronavirus Health and Response Agency Operations (2020)

the resources they need to sustain a vigorous response. Efficient distribution of support from the Fund directly to these frontline providers will be instrumental to help the country navigate this emergency as quickly as possible. **The distribution of the funds should be quick and come directly from HHS to eligible providers.**

Specifically, in determining the process, methodology, and funding levels for disbursement from the Fund, we ask you to give priority to the following criteria for which data is easily known:

In distributing funding for hospitals, HHS should prioritize funding levels for facilities that have enhanced capabilities, experience, and have taken steps to mount a response, as demonstrated through the following criteria:

- Historical experience managing care for highly complex patients, as demonstrated by:
 - case mix index (CMI),
 - patient transfers received, and
 - number of Intensive Care Unit (ICU) beds;
- Care for financially vulnerable patient populations, as demonstrated by Disproportionate Share Hospital (DSH) patient percentages, or a comparable measure;
- Size, as demonstrated by number of beds; and
- Number and complexity of COVID-19 patients.

In addition, providers in current “hot spots” should be given particular support to offset the current expenses they are sustaining.

There should also be robust support for providers that have met the above criteria in communities that have not yet experienced a surge, but are preparing vigorously for a pending surge in cases.

Using these criteria will allow HHS to disburse funds quickly to hospitals, recognizing that hospitals will ultimately need to demonstrate the needs for these funds through some type of reconciliation process.

In distributing funding for physician practices, HHS should prioritize physician practice groups that do not qualify for small business loans made available by the CARES Act and the level of disbursement should be based on lost revenue as determined by the prior six month period or a comparable month(s) from the prior year.

Providers will be affected in different ways and at different times during this pandemic, so they should have the opportunity to apply for and receive funds multiple times for both retrospective and prospective needs.

The following provides additional detail on the role of academic medicine in this crisis and these recommendations for the Fund.

HOW ACADEMIC MEDICINE IS RESPONDING TO THE PANDEMIC

Our teaching hospitals provide 25% of the nation's medical and surgical intensive care beds, 36% of cardiac intensive care beds, 61% of pediatric intensive care beds, and are home to 69% of all Level 1 Trauma Centers. Our members are well-established and respected regional referral centers and centers for tertiary care. They have years of experience in mobilizing resources during a time of crisis, and often lead regional responses in collaboration with their state and local departments of health, regional emergency management systems, and all other major players in emergency response. States and localities look to our members for launching initial responses and to aid the development of regional response networks.

As major centers of medical research in addition to patient care, scientists at medical schools and teaching hospitals conduct over 50% of extramural research funded by the National Institutes of Health (NIH). Many of our member institutions have developed much-needed tests for COVID-19, a fluid and rapidly changing area as they bring new equipment online, try to source materials, and stand up reporting procedures in battlefield-like conditions. Our members continue to provide the world's most advanced and expert patient care informed by the latest innovations in fundamental and clinical research. Our emergency rooms are open to anyone in need, with experts in medical specialties available 24/7.

Major teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19. Across the country, AAMC members have been executing their emergency response plans and protocols and working closely with their colleagues at state and local health departments.

As we have heard from our members and seen on national news reports, COVID-19 patients tend to be sicker and require prolonged hospitalizations, including being placed on ventilators in intensive care units. While we appreciate the increase in the Medicare Severity-Diagnosis Related Group (MS-DRG) relative weights included in the CARES Act, we are concerned that it will not cover the unique costs associated with treating COVID-19 patients. Teaching hospitals will treat the majority of these complex patients and, for many of these patients, the cost of care will greatly exceed the reimbursement hospitals receive.

Our data analysis shows that teaching hospitals, while roughly one-third of all Medicare Inpatient Prospective Payment System (IPPS) hospitals, treat 61% of all cases requiring long-term ventilatory support and/or peripheral extracorporeal membrane oxygenation (ECMO) (MS-DRG 207). Moreover, these hospitals treat 59% of all patients requiring short-term ventilator support (MS-DRG 208).² Early reports from member hospitals are that the length of stay for COVID-19 patients is significantly higher than for other patients, including longer ICU stays.

Additionally, AAMC member teaching hospitals and physicians are preparing for the rise in admissions of COVID-19 patients by cancelling non-essential, elective procedures and discharging patients. Our members report that occupancy rates have dropped by as much as 30%

² AAMC Analysis of Medicare hospital inpatient claims from the FY2018 Medicare Provider Analysis and Review (MedPAR) database.

to prepare for surges in COVID-19 cases. As a result, there will be dramatic revenue losses sustained by hospitals and the physicians who perform these procedures. Because many major teaching hospitals typically operate at capacity, these losses may never be recoverable for many of these hospitals and physician groups. And the increase in the MS-DRG weights will not make up for these shortfalls. Therefore, it is imperative that disbursements from the Fund established in the CARES Act assist teaching hospitals and their faculty physicians in alleviating these dramatic losses.

Moreover, because of the expertise of their teaching physicians, health care teams, and cutting-edge medical technology, AAMC-member teaching hospitals and physicians provide care for complex patients and often receive transferred patients who are medically complex and require specialized care that only teaching hospitals can provide. Our members report an increase in the number of transferred COVID-19 patients.

Major teaching hospitals consistently maintain a heightened level of preparedness to mobilize rapidly in response to any event at any time. This unique proficiency helped to lead the nation's response to past public health emergencies and disease outbreaks such as measles, Ebola, and H1N1, and now is a key asset in combatting COVID-19. And even in the midst of this crisis, teaching hospitals currently battling a surge in infections and managing the needs of their communities are sharing their knowledge with others.

For example, the University of Washington, which was among the first to treat large numbers of COVID-19 patients, developed protocols and made them along with other information available on its website, as have Duke University School of Medicine, Massachusetts General Hospital, and Johns Hopkins Medicine. Physicians from University of Nebraska Medical Center, Emory School of Medicine, Rush University Medical Center, and the University of Washington spoke on a recent call with the Centers for Medicare & Medicaid Services (CMS) to share what they have learned with the physician community at large. AAMC-member hospitals are sending us information to be consolidated on a publicly available portion of our website.

These examples are but a few of the ways that teaching hospitals and physicians are not only spearheading the response in their local communities, but also are an invaluable asset in supporting the entire health care system and eliminating the threat of COVID-19 nationwide.

RECOMMENDATIONS ON DISTRIBUTION OF FUNDS

To ensure consistency and swiftness in allocating resources from the Fund, it is essential that HHS manage distribution centrally, review applications quickly, and use consistent, uniform criteria to distribute the funds directly to health care providers. To facilitate these objectives, we recommend ensuring that the application process be as simple as possible. As indicated in the legislation, funding should support both retrospective and prospective needs for the duration of the public health emergency. With the rolling processing of applications, HHS should explicitly allow providers to submit multiple applications at varying times to ensure support for expenses that are less predictable. Additionally, HHS should make available on its website at least

monthly details of the total amounts providers apply for in excess of the total amount of the Fund.

We know that many hospitals and physicians treating COVID-19 patients need support. We also are aware that many entities may apply for the funds. However, we ask HHS to recognize that teaching hospitals and associated physicians are assuming a disproportionate burden of the costs to care for these medically complex patients by providing drive-through testing centers, expanding bed capacity, securing extra ventilators, and purchasing personal protective equipment, among other essential efforts. As you make Fund disbursement decisions, we urge you to proceed expeditiously to equip major teaching hospitals and faculty physicians across the country with the resources they need to sustain a vigorous response. Efficient distribution of support from the Fund directly to these frontline providers will be instrumental to help the country navigate this emergency as quickly as possible.

Specifically, in determining the process, methodology, and funding levels for disbursement from the Fund, we ask you to give priority to the following criteria for which is data is easily known:

HOSPITAL DISBURSEMENT CRITERIA AND CONSIDERATIONS

Recommended Criteria

HHS should prioritize funding for facilities that have enhanced capabilities and experience, and have taken steps to mount a response, as demonstrated through the following criteria that can be easily obtained through existing data sources. HHS should review a hospital's experience managing care for highly complex patients, as demonstrated by (1) its case mix index (CMI), (2) the number of patient transfers received, and (3) its number of ICU beds. Next, a hospital's care for financially vulnerable patient populations, which could be ascertained from a hospital's DSH patient percentages, or a comparable measure. The overall size of the hospital, determined by the number of beds would also inform an assessment of a facility's enhanced capability and experience, in addition to the number and complexity of COVID-19 patients the hospital is treating.

Medically complex and vulnerable patients who cannot be cared for elsewhere will be predominantly treated at teaching hospitals. These hospitals will have more ICU beds and greater ventilators-to-bed ratios. This will help to ensure that those hospitals with greater capacity for complex cases are properly compensated.

COVID-19 patients are sicker and require a higher intensity of care. Many of these patients will be transferred to teaching hospitals that treat a disproportionate share of transfer patients from other hospitals.³ Transfer patients have been found to be higher acuity than average patients — they spend more time in the ICU, are less likely to discharge directly to home, and ultimately cost more to treat. Teaching hospitals have demonstrated that they are uniquely able to provide

³ AAMC Analysis in Brief. Teaching hospitals are critical providers of care for Medicare Transfer Patients. July 2019. Available at <https://www.aamc.org/system/files/2019-07/june2019teachinghospitalsarecriticalprovidersofcareformedicareh.pdf>

specialized services or intensity of care to these patients when other hospitals are not equipped to deliver such care.⁴

In addition, providers in current “hot spots” should be given particular support to offset the current expenses they are sustaining.

There should also be robust support for providers that have met the above criteria in communities that have not yet experienced a surge, but are preparing vigorously for a pending surge in cases.

Additional Considerations

HHS should consider the following additional expenses when determining disbursement sums for hospitals that meet the above criteria:

Lost Revenue

The CARES Act explicitly establishes the Fund to assist providers in recovering revenue losses attributable to their COVID-19 efforts. As noted previously, teaching hospitals are expected to lose significant revenue during the pandemic that most likely cannot be recovered. Teaching hospitals and health systems are reporting losses ranging between \$2 and 8 million per day. As hospitals apply to the Fund to recover lost revenue, we suggest as one possibility that HHS calculate such sums by comparing revenue from the prior six months or from 2019 in comparison to actual revenue for the same month in 2020.

Actual Expenses for Care Delivery During the Pandemic

In addition to these losses, AAMC-member teaching hospitals are incurring significant costs to prepare and care for COVID-19 patients and potential patients. Examples of those expenses are as follows:

- Teaching hospitals continue to struggle with securing personal protective equipment (PPE) for their facilities. Our members report paying ten times the amount they customarily pay for PPE, with some paying as much as 20 times.
- Teaching hospitals are purchasing or expanding their technology for telehealth to provide on-site care via telehealth to reduce exposure and better allocate limited PPE resources.
- Teaching hospitals are creating short-term spaces to triage and screen patients. Some of our members have erected temporary buildings and/or are retrofitting non-clinical spaces such as dormitories to accommodate the surge in COVID-19 patients.
- Teaching hospitals are securing hotel rooms for physicians and staff to limit the possibility of hospital staff passing COVID-19 to their family members and are incurring childcare expenses for their workforce to enable staff to come to work, in addition to meal expenses to feed providers during surge shifts.
- Teaching hospitals are increasing their workforce by employing additional staff – temporary workers, retired doctors and nurses – in order to ensure adequate staffing ratios

⁴ Ibid.

during the pandemic. This also requires additional training on hospital systems such as electronic health records for new staff. Some medical schools are graduating medical students early to help with the surge of patients. Teaching hospitals will be required to expand capacity in intensive care units and deploy additional specialized staff to care for patients requiring ventilator support.

Expenses Associated with Expanding Testing Capacity

Teaching hospitals with in-house laboratory testing have developed their own rapid test capabilities, or partnered with such laboratories, to serve the hospitals' patient populations in a timely manner and overcome the backlog of testing in commercial and reference labs in order to effectively triage and treat COVID-19 patients. This effort has required immediate and unplanned expansion of laboratories, including the purchasing of new equipment and the diverting of lab resources to work through supply chain issues and maximize the hospitals' testing capacity.

Expenses for Pandemic Preparedness and Public Health Partnerships

AAMC-member hospitals often have direct links with local and state public health departments, as well as other community providers, including serving as *de facto* leads for regional/state/local response. Academic medical centers lead efforts to provide direct big data, epidemiology, modeling, and other analytic support for state and local health departments. For example, UMass Memorial has worked with both city and state officials to plan a 250-bed field hospital at the city convention center, where UMass Memorial will lead all medical planning, staffing, and licensing as part of their Medical Center. HHS should consider these investments and partnerships for additional funding.

PHYSICIAN PRACTICE DISBURSEMENT CRITERIA AND CONSIDERATIONS

Recommended Criteria

HHS should prioritize funding for large physician practices that do not qualify for small business loans made available by the CARES Act.

Large physician practices that employ over 500 individuals are unable to qualify for small-business relief through other means provided in the CARES Act. These practices, including independent faculty practices, should receive priority for compensation from the Fund compared to those practices that can seek relief through other available channels. Faculty practices directly tied to teaching hospitals and health systems have contributed to the broader system preparation for surge capacity. They are providing additional staffing support in teaching hospitals and are also staffing the newly opened beds and clinics that will be used for current and future patients during this crisis.

As background, teaching physicians who work at academic medical centers (AMCs) provide care in what are among the largest physician group practices in the country. Teaching physicians

typically have faculty appointments at medical schools through affiliations and other agreements and provide care in both the outpatient and inpatient settings. Faculty practices on average have 989 physicians, in addition to employing other clinical and administrative staff. They are often organized under a single tax identification number (TIN) into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Care is often multidisciplinary and team based.

AMCs provide primary care services for their local communities. However, a large percentage of the services provided by teaching physicians are for tertiary, quaternary, or specialty referral care. These faculty practices treat a disproportionate share of patients for whom social determinants of health, such as housing, nutrition, and transportation, contribute significantly to additional health challenges, adding greater complexity to their care and further adding to the challenge of treating COVID-19 patients.

The COVID-19 crisis is causing significant disruption to these types of physician practices due to the cancellation of elective procedures and other nonurgent patient care visits. Many of the employees of these physician practices, such as nurses, and resources, such as PPE, are being redeployed to the front line of caring for patients. To protect patients from exposure to the virus and conserve resources for the epidemic, physicians are heeding the call to suspend most elective in-person visits and replace them with virtual visits to the extent possible as requested by the Centers for Disease Control and Prevention (CDC), other public health authorities, and their own professional societies. To the extent possible, they are postponing the majority of elective surgeries as requested by CMS.

Additional Considerations

HHS should consider the following additional expenses when determining disbursement sums for physician practices that meet the above criteria:

Lost Revenue

Financial assistance is desperately needed to ensure the longevity and ability of these practices to provide care to patients for the duration of this crisis and into the future. Teaching physicians need to be able to sustain their practices, provide their patients with the best possible care during the COVID-19 emergency, and continue to teach residents and medical students. This national emergency is putting severe financial pressure on physicians, and all types of practices and specialties, because most payers, including Medicare, pay physicians based on the number of in-person visits and procedures they provide. While some services (e.g., evaluation and management services) can be provided by telehealth, many procedural based services cannot. Practices are experiencing significant and extensive losses in revenue while still having to maintain the payment of their expenses, including costs associated with facilities, payroll, malpractice liability, and others. It will be impossible for these practices to make up for this lost revenue.

To compensate for lost revenue, we recommend that HHS calculate lost revenue payments to physician practices based upon a comparison of monthly revenues from prior six months or from

2019 in comparison to actual revenue for the same month in 2020. Lost revenue should be determined based on revenue from all payers (not just Medicare/Medicaid).

Actual Expenses for Care Delivery During the Pandemic

HHS should reimburse practices for added practice expenses to support care delivery during the emergency, like PPE, the establishment of additional sites for testing and treatment of COVID-19 patients, the purchase or expansion of technology for telehealth to divert patients from on-site care where possible, and the additional training physicians need to provide telehealth services.

CONCLUSION

The AAMC appreciates your consideration of our recommendations for disbursing support from the Provider Relief Fund established in the CARES Act, and we look forward to continued cooperation between our members and HHS during this critical time. Should you have any additional questions, please do not hesitate to contact me directly or AAMC Chief Health Care Officer Janis M. Orłowski, MD (jorłowski@aamc.org) and AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org).

Sincerely,



David J. Skorton, MD
President and Chief Executive Officer
Association of American Medical Colleges

Cc: The Honorable Eric Hargan, Deputy Secretary
The Honorable Brett Giroir, MD, Assistant Secretary for Health
The Honorable Robert Kadlec, MD, Assistant Secretary for Preparedness and Response
The Honorable Seema Verma, CMS Administrator