AAMC

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

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) Public Health Emergency (PHE) and to offer our assistance and recommendations on future funding allocations from the Provider Relief Fund (Fund) initially established in the "Coronavirus Aid, Relief, and Economic Security Act," (CARES Act, P.L. 116-136), and expanded in the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139).

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.

Because of their expert faculty physicians, health care teams, and cutting-edge medical technology, AAMC member teaching hospitals provide care for complex patients and often care for patients who are unable to receive care elsewhere. For example, our teaching hospitals provide 23% of inpatient psychiatric unit beds, 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. AAMC member teaching hospitals have invested substantially in mental and behavioral services, expanding access to their communities in need. In implementing their years of experience of mobilizing resources during times of crisis, AAMC member teaching hospitals and physician practice plans 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. Their communities know that their emergency rooms are open to anyone in need, with experts in medical specialties available 24/7.

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.

The COVID-19 pandemic has posed enormous challenges and has placed tremendous stress on our entire health care system – and teaching hospitals, medical schools, and teaching physicians have mobilized on all fronts to contain and mitigate COVID-19 and to freely share the knowledge that they gain with others. 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 to serve as first responders. We are grateful that Congress has continued to invest in the Provider Relief Fund and recognize the tremendous efforts made by the Department of Health and Human Services (HHS) to quickly distribute allocations from the Fund. We realize that many types of providers across the country are demonstrating financial need as the pandemic progresses, and we recognize the inherent complexity and challenges of distribution. We urge you to distribute the remaining funds from the Provider Relief Fund expeditiously so that providers can continue operations.

Our member teaching hospitals and physicians continue to need additional financial resources as they respond to, and are impacted by, the pandemic. Due to the long-term nature of this crisis, financial relief for these front-line providers is critical. While they do not expect to be made financially whole by distributions from the Fund or through other federal relief measures, these additional resources are instrumental to ensuring that hospital and physician practice doors can remain open and continue to sustain a vigorous response to the pandemic; maintain the necessary health care workforce; and ensure that patients can continue to get the testing, treatment, and care they need.

We estimate that teaching hospitals are losing between $2 and $8 million *per day*, and physician faculty practice plans are reporting revenue losses of between 25% and 50% as compared to 2019. While these institutions and practices are routinely treating the most vulnerable and complex patients, they also are faced with mounting financial impacts from the combination of a suspension of non-urgent elective procedures, and the costs of preparing for and responding to patient surges, among other efforts to support their communities and their staff.

As HHS works to distribute the remaining resources from the Fund, we recommend that you implement the following principles to prioritize the allocations:

- Ensure that safety-net providers caring for vulnerable populations receive sufficient funding.
- Distribute a second targeted tranche of funding for providers treating disproportionate numbers of COVID-19 patients and update the "high impact" distribution date from its original April 10th date to account for new "high impact" areas that have developed since

that time, while recognizing that some of the original "high impact" areas continue to be "high impact."
- Utilize the intensive care unit (ICU) bed data collected previously as a proxy to provide additional funding for hospitals with a higher share of ICU beds and consequently higher acuity patients.
- Sufficiently recognize and reimburse the significant lost revenue incurred by teaching hospitals and faculty physicians. Because these providers, under normal operations, have high occupancy rates and full patient schedules, they will not be able to recover revenues lost during the pandemic. Without relief to fill this financial gap, not only will future clinical activities be affected, but academic providers also will be forced to reevaluate their support for education and research because they will have fewer resources.
- Recognize the unique contributions and costs of academic medical centers that have not only faculty physicians on the front lines but also residents and other learners. While maintaining an environment where education and training can flourish is a significant investment in non-pandemic times, costs mount significantly as learners in their residencies are providing front line care with their supervising physicians.

Additionally, the AAMC recommends that HHS consider:
- The unique needs of faculty practice plans, which should receive targeted funding.
- The need for expeditious disbursement of funds and clarification on the amounts distributed.

RECOMMENDATIONS FOR DISTRIBUTION OF FURTHER FUNDS

The AAMC recognizes your efforts to dispense the funds quickly and directly to providers and is appreciative of the expeditious distributions to date. Teaching hospitals and many faculty physicians received funds from the initial allocations and were able to quickly deploy those dollars to mitigate the financial impact of their response efforts. However, it is clear that more is needed, particularly for teaching hospitals and faculty physicians, who are bearing unique and increasing costs as they respond to this crisis.

The AAMC asks HHS to be more explicit in explaining the methodology for additional distributions of resources from the Fund. Some of our members have expressed confusion around the broad allocations and their distribution. In addition, the AAMC recommends a more streamlined application process that allows providers to clearly state their COVID-19 related expenditures and lost revenue, which could help to address the confusion and simplify the process. While our members understand that under the current Terms and Conditions they will have to account for and demonstrate their costs, more explicit requirements will help them prepare for the reports that must be submitted. Additionally, the AAMC asks that HHS use consistent definitions throughout the Terms and Conditions to mitigate confusion.

As you work to distribute the currently remaining funds in the Provider Relief Fund, the AAMC urges you to allocate additional resources based on the following:

Providers Caring for Vulnerable Patients
Though the first rounds of funding were open to a large number of providers, it is clear that many providers who typically see a lower volume of Medicare patients or for whom net patient revenue is typically lower require additional attention. Many of the nation's teaching hospitals and medical school physician practice plans care for significant Medicaid populations, and these safety-net providers continue to treat high-cost, high need patients with already limited financial resources, and should be recognized with additional funding through the Provider Relief Fund. The AAMC recommends that HHS allocate funds to safety net providers who are caring for financially vulnerable populations. This metric could be ascertained from a hospital's disproportionate share hospital (DSH) patient percentages, or a comparable measure. For example, HHS already used Medicare DSH data to distribute additional Provider Relief Funds as part of the targeted "high impact" allocation.

Providers Seeing Large Influxes of COVID-19 Patients
HHS has already distributed funds to hospitals in "high impact" areas, who have seen over 100 COVID-19 patients before April 10, 2020. The AAMC recommends that HHS distribute another round(s) of "high impact" funds to those hospitals that meet the 100-case threshold after the April 10 date, including those that may have received funds in the first round and continue to meet the criteria for "high impact" areas. As the pandemic progresses, there will be surges across the country in varying locations and at different times. The AAMC recommends that HHS continue to distribute "high impact" funds to aid providers on the front lines of new outbreaks as well as those that continue to be in "high impact" areas. Additionally, the AAMC recommends that "high impact" funding not be limited to hospitals but include faculty practice plans in future distributions.

Hospitals with High Numbers of ICU Beds
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. The AAMC recommends that HHS utilize the data it has already collected on hospitals' ICU bed capacity to make additional allocations from the Fund.

As we have heard from our members and seen on national news reports, COVID-19 inpatients tend to be sicker and require prolonged hospitalizations, including being placed on ventilators in ICUs. Teaching hospitals are treating many of these complex patients, and the cost of their care exceeds the reimbursement that hospitals receive. Moreover, because of the expertise of their health care teams and cutting-edge medical technology, AAMC-member teaching hospitals and teaching physicians also often treat patients transferred from other hospitals who are medically complex and require specialized care that only teaching hospitals can provide. 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. We also know from our members that they are receiving a disproportionate share of COVID-19 patients as compared to their traditional market share. This disproportionate share exists even in areas where there is a lower incidence of disease, and these providers should be recognized for their service to the greater community. Teaching hospitals have demonstrated that they are uniquely able to provide specialized services or intensity of care to these patients when other hospitals are not

equipped to deliver such care.[1] In fact, our members report an increase in the number of transferred COVID-19 patients.

UNIQUE NEEDS OF FACULTY PRACTICE PLANS

Faculty practice plans, which are multi-specialty group practices comprised of teaching physicians who work at academic medical centers, are facing unique struggles as they respond to the COVID-19 pandemic. Teaching physicians typically have faculty appointments at medical schools and provide care in both outpatient clinic and inpatient hospital settings while also training residents and teaching medical students and others. On average, the AAMC members' faculty practices have 989 physicians – making them among the largest physician group practices in the country – 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 routinely deliver team-based care to the most complex and vulnerable patient populations, many of whom require highly specialized care.

Teaching physicians provide critical services for their local communities, including a large percentage of tertiary, quaternary, or specialty referral care. They also 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. These are the very patients that are experiencing the disproportionate health and societal burden of this pandemic.

The COVID-19 crisis is causing significant disruption to these physician practices due to the cancellation of elective procedures and other nonurgent patient care visits. Though many teaching physicians continue to provide care in teaching hospitals as they treat COVID-19 patients and others, once the crisis subsides they will return to performing critical research and training the next generation of physicians.

To continue caring for patients, teaching hospitals and faculty practice plans alike have rapidly and vastly expanded their telehealth capabilities. Faculty practice plans, in particular, have switched swiftly to telehealth, with reports from AAMC members that some have moved from 4-5 visits per week to thousands per week, and that others report conducting fifty percent of their ambulatory visits via telehealth. However, this transition has not been without costs, including implementing telehealth and training physicians, staff, and patients on the technology.

While telehealth has enabled the continuation of many services during the crisis, it still has its limitations. Some medical services, particularly procedures furnished by specialists, cannot be provided remotely. Practices have been able to make up for only a fraction of their lost revenue through telehealth services. In addition, although the AAMC is appreciative of the increased payment of telehealth services in the Medicare program, many commercial payers have not

[1] 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

followed suit. Even with broader increased payment for some services, there are a number of procedural based services that cannot be performed via telehealth.

Faculty practice plans have tried to avoid furloughs by redeploying staff where possible, but the costs of maintaining a practice, including facilities, payroll, malpractice liability, and others are mounting. Even when more normal operations are able to resume, it will be impossible for these practices to make up this lost revenue. The process of ramping up operations comes with unique costs as practices need to purchase personal protective equipment (PPE), increased testing for staff and patients, enhanced cleaning protocols, and other costly measures – all while seeing a lighter patient volume to maintain adequate social distancing.

It is clear that 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 and to ensure that the current cadre of teaching physicians will be able to conduct research, teach, and lead efforts aimed at improving the health of their communities. After initial delays, we appreciate that faculty practice plans ultimately received support from the second distribution of the Provider Relief Fund. It is critical that HHS quickly provide future Provider Relief Fund dollars to these providers, and we ask HHS to expedite these funds in future allocations.

To compensate for lost revenue, we recommend that HHS calculate lost revenue payments to physician practices based upon a comparison of monthly revenues from the 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).

In addition, we believe special consideration should be given to teaching physicians who have incurred additional, unique costs related to the COVID-19 pandemic. One option would be to provide faculty practice plans with additional funding by having faculty physician practices attest to their status as a faculty physician practice.

NEED FOR EXPEDITIOUS DISBURSEMENT OF FUNDS AND CLARIFICATION ON THE AMOUNTS DISTRIBUTED

Though the AAMC appreciates the rapid pace at which HHS has distributed initial allocations from the Fund, some faculty practice plans experienced delays from the second distribution. We ask that HHS, to the extent it is able, ensure that the funds are distributed expeditiously.

Additionally, there has been some confusion about the amounts that providers should be receiving from the Provider Relief Fund. For example, Frequently Asked Questions (FAQs) released by HHS on May 14, 2020 indicated that the general distribution funds would be calculated "based on the lesser 2% of a provider's 2018 (or most complete tax year) net patient review or the sum of incurred losses for March and April" and further that "if the initial General Distribution payment you received between April 10 and April 17 was determined to be at least 2% of your annual patient revenue, you will not receive additional General Distribution

payments."[2] The AAMC is concerned that this 2% threshold is low and not reflective of the enormous losses incurred by providers.

Finally, Provider Relief Fund allocations should continue to be distributed directly to providers. Congress provided several streams of funding to respond to the COVID-19 emergency encompassing many institutions, businesses, and government agencies in need – but the Provider Relief Fund was specifically designed to give immediate and desperately needed financial resources to providers on the front lines of the pandemic. While the funds disbursed to date have been very helpful, both hospitals and physicians are still facing extreme financial challenges due to the PHE. It is critical that more fund distributions are rapidly and directly made to the providers that need them most.

CONCLUSION

The AAMC appreciates your consideration of our recommendations for disbursing additional support from the Provider Relief Fund. Please consider the AAMC a resource, and should you have any additional questions, please do not hesitate to contact me directly or AAMC Chief Public Policy Officer Karen Fisher, JD (kfisher@aamc.org) or AAMC Chief Health Care Officer Janis M. Orlowski, MD (jorlowski@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 Seema Verma, CMS Administrator
The Honorable Brett Giroir, MD, Assistant Secretary for Health
The Honorable Robert Kadlec, MD, Assistant Secretary for Preparedness and Response

[2] CARES Act Provider Relief Fund Frequently Asked Questions: https://www.hhs.gov/sites/default/files/provider-relief-fund-general-distribution-faqs.pdf