

June 26, 2020

The Honorable Lamar Alexander  
United States Senate  
455 Dirksen Senate Office Building  
Washington, DC 20510

Dear Senator Alexander:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide input on the ideas set forth in “Preparing for the Next Pandemic.” COVID-19 continues to challenge our health care system and public health infrastructure like no other emergency during our lifetimes. While we are firmly committed to a thorough examination of how we improve our ability to respond to future emergencies, Congress must recognize that the current pandemic remains a present challenge.

America’s hospitals and health systems play a critical role in all types of disasters and public health emergencies. Often, as has been the case with COVID-19, they serve as the front line of response, caring for the sick and collaborating with federal, state, and local emergency response teams, including carrying out a number of public health functions from testing to public education. We agree that there is much we must learn from the COVID-19 pandemic and that there are significant opportunities to strengthen our nation’s preparedness and response capabilities and capacities. We appreciate the opportunity to provide insights from hospitals’ and health systems’ experiences, and our detailed comments follow. However, we recognize that we are still in the initial response to COVID-19, and we hope this will be part of an ongoing dialogue as we continue to move through response and into recovery and rebuilding.

### **Health System Financing During Public Health Emergencies**

In order to respond to public health emergencies, hospitals and health systems often must retrofit physical infrastructure, retain additional workforce capacity, and secure new and different supplies or quantities of supplies. For example, during COVID-19, hospitals and health systems retrofitted or built new patient care space to isolate infected patients and minimize spread; built new testing capacity in parking lots and in the community; hired additional nurses and other clinical personnel; developed and



deployed new facilities management protocols; and, critically, reduced clinical volume of much non-COVID-19 care in order to preserve supplies and minimize opportunities for infection. Each of these steps requires additional resources or, in the case of cancelled care, reduces hospitals' and health systems' available resources.

To support the critical role of hospitals and health systems during public health emergencies, the AHA has advocated for more than 15 years for increased funding for the Hospital Preparedness Program (HPP) due to the ever-changing and growing threats, which hospitals, health care systems and communities face. When initially implemented, the HPP program covered certain preparedness costs incurred by hospitals and health systems. Over time, the HPP program changed to cover the costs for regional health care coalitions and it no longer directly covers the costs for hospital and health system preparedness. The lessons of the many recent catastrophic emergencies and disasters prior to COVID-19, including hurricanes in Texas, Florida and Puerto Rico, mass shooting in Las Vegas, wildfires in California and measles outbreaks, as well as the threats posed by possible chemical, biological, radiological and nuclear events and emerging infectious diseases support the need for a much more significant and sustained investment in health care system preparedness, including a direct fund for hospitals and health systems. The COVID-19 pandemic has again highlighted the federal government's lack of investment in hospital and health system preparedness. **The AHA strongly advocates for a modernized HPP program to directly fund hospitals and health systems to ensure they have the necessary resources to be prepared in light of all the threats our nation faces. We urge increased funding of at least \$750 million a year for the HPP program.**

The COVID-19 pandemic has proven that the HPP is wholly insufficient and not designed to assist hospitals and health systems with financial insecurity during an emergency. The financial losses due to the cancellation of health care services during COVID-19 have been devastating to hospitals and health systems. The AHA estimates a total financial impact of \$202.6 billion in losses resulting from COVID-19 expenses and lost revenue for hospitals and health systems over the four month period from March 1, 2020 to June 30, 2020 – or an average of over \$50 billion in losses a month. An emergency fund to ensure that hospitals and health systems would not collapse just as we needed them the most was established in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). **There needs to be a permanent fund established that would quickly be activated to directly fund hospitals and health systems during emergencies so that health care services will be available regardless of the negative economic impact of any emergency. The lack of such a permanent fund is a major vulnerability in our nation's health care system preparedness.**

While preparing for the next pandemic will improve our nation's overall readiness, we cannot lose sight of the other threats that our nation faces. We urge the Health, Education, Labor & Pensions Committee and Congress to view preparedness from an all-hazard perspective so that we can best be prepared to respond to the next

emergency, whether it is man-made, a weather emergency or an emerging novel virus. We support the following initial recommendations presented in the white paper:

1. Improvement of the medical and pharmaceutical supply chains, including the development of additional domestic manufacturing capacity for raw material, active pharmaceutical ingredients and finished products and increased availability of critical medications. Our front line health care workers rely on medical supplies, like personal protective equipment to keep them safe so they can care for patients; without access to those supplies, providers are left underprepared in this effort. Further, without access to the pharmaceutical supplies necessary to care for patients, front-line workers are underequipped to manage patient needs.
2. Continued support of the National Institute of Allergy and Infectious Diseases for vaccine and treatment trials.
3. Coordination among the federal government to implement the Medical Countermeasure Innovation Partner program.
4. Engagement and partnerships with the private sector for the purposes of testing and disease surveillance. To ensure more timely and accurate surveillance information, we encourage a process for automated sharing of information, leveraging the various electronic health care record platforms used across the country.
5. Rebuild and maintain federal Strategic National Stockpile (SNS) and state stockpiles and improve medical supply surge capacity and distribution. Ensuring the availability of adequate and appropriate supplies is absolutely necessary when facing any emergency, especially a national emergency as challenging as COVID-19. Hospitals and health systems rely on a variety of medical supplies in order to provide the safest, highest quality care to patients. Any unavailability of supply threatens the ability of providers to meet patient need. In order to meet immediate supply demand in times of emergency, clear and concise communication between the federal government and state and local governments is vital to ensure each entity's role is clear. Moving forward, these stockpiles should be collaborative efforts and maintained according to likely supply need. We are encouraged by the Administration's "Strategic National Stockpile 2.0" initiative to restock and revamp the SNS and to improve SNS inventory management and distribution. As described, the initiative envisions drawing upon private industry partners to store and manage inventory, to enter contracts for reserved capacity, and to provide logistics services to allow for rapid identification and distribution of supplies to hotspots. Moving forward, we believe that the SNS and state stockpiles are necessary to provide supplemental assistance when there is no other option; however, the stockpiles should be

relied on as a short-term stopgap measure to provide manufacturers with a short period of time to ramp up production and meet demand.

6. Improvement of coordination between federal agencies.
7. Developing a plan to get Americans back to their routine health care safely and allow for health care providers to provide care during a pandemic.
8. Ensuring the United States does not lose the gains made in telehealth.
9. Improving states' capacity to contact trace and providing for increased capacity when necessary.
10. More training for emergency preparedness and additional national exercise plans.

### **Telehealth Capabilities**

As we see from the COVID-19 pandemic, the ability for patients to receive care in their homes was essential to “flattening the curve” and to keeping patients and providers safe. As enumerated in your recommendations, we urge Congress and the Administration to act so as to avoid losing these and other gains in the delivery, coverage and reimbursement of telehealth services. Of course, providing telehealth services requires providers who are trained and available to do so as well as patient access to providers regardless of their location. However, due to significant state variation in licensing requirements and reciprocity, the availability of telehealth services is fragmented across the nation. This fragmentation led to confusion and delay during the current pandemic and could lead to long-term reduction in access for patients in certain areas of the country.

We further urge congressional action in the following areas:

- Allow patients to receive telehealth services in their homes and other locations, and in any area of the country. Current law and regulations limit coverage of telehealth to rural areas and require patients to come into certain facilities to receive telehealth services. The COVID-19 pandemic experience has demonstrated the value of these services and their popularity among patients looking for a more seamless experience of care. We urge a permanent change in policy to facilitate broader adoption of these capabilities, as well as patient comfort with their use, which will ease our response to any future communicable disease outbreak.
- Allow rural health centers (RHCs) and federally qualified health centers (FQHCs) to serve as distant sites for the provision of telehealth services.

- Allow 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.
- Allow hospital outpatient department billing for telehealth. Allow hospitals, including critical access hospitals, to bill the outpatient perspective payment system, or otherwise applicable hospital payment systems, for therapy, education and training services, and other appropriate services remotely furnished to Medicare patients by hospital clinical staff.
- Allow hospitals to bill an originating site facility fee for remote services provided to patients in their home.
- Allow, as clinically appropriate, certain Medicare telehealth services to be delivered via audio-only communication and maintain increased payment for telephone evaluation and management codes.
- Allow telehealth to be used to perform (1) face-to-face visits for the purpose of recertifying Medicare hospice services and (2) home health face-to-face encounters. In addition, allow professionals who provide home health and hospice services (including nurses and therapists) to do so via telehealth and bill accordingly.

### **Health Care Coverage as a Public Health Function**

While not specifically outlined in the white paper, it is critical to comment that health care coverage plays an essential role in public health emergency response. Stopping the spread of communicable disease requires that every individual in a community have access to public health information, preventive care and treatment. Access to medical care is not simply about keeping an individual healthy, it also is about ensuring that as few individuals as possible catch and then transmit disease. In other words, in the face of communicable disease, we all are only as safe as our weakest link. As a result, public health interventions require universal access to care – something that we have not yet achieved in this country.

A major weak link in our public health response to COVID-19 has been the high rate of uninsured individuals. Today, approximately 10% of individuals nationally are uninsured, but that figure reaches nearly 20% in some states. Individuals without health care coverage are less likely to have a routine source of care and are more likely to face financial barriers to care. That means uninsured individuals may avoid testing or treatment because they do not know where to go or out of fear of what the care may cost them and remain in the community without appropriate safeguards to prevent transmission.

Temporary measures, such as those implemented by HHS to provide reimbursement for uninsured COVID-19 patients do not suffice. They are often limited in scope, may be unknown to the uninsured, and do not facilitate the ongoing relationship between an individual and the health care system. In short: health care coverage is a prerequisite for routine access to care. **We must close the coverage gaps in order to ensure appropriate access to care.**

Gaps in coverage also deprive public health experts of an important communication and surveillance vehicle. Health plans and other coverage programs have mechanisms for getting in touch with their enrollees in ways the government does not: They have their phone numbers, emails and addresses, as well as an established relationship that is based on the sharing of health-related information. Instead of relying on general public service announcements, health plans and other coverage programs can directly reach out to enrollees with targeted communications. They also can monitor claims data to assess whether individuals are getting the care they need. For example, health plans can monitor which enrollees have already received a vaccine and target communications to those who have not.

Health care coverage also is critical for ensuring that the health care system is adequately financed. COVID-19 demonstrated how a global pandemic can financially upend the health care system and the broader economy, ultimately leading to inadequate financial resources to keep providers open and serving their communities. The growing rate of uninsured, as well as the shift from commercial coverage to Medicaid, is further exacerbating the financial struggles of many providers. Gaps in coverage weaken providers' financial positions as they are not compensated for the care they provide. Even when ad hoc programs are established to reimburse for some COVID-19 care, these are limited-scope programs that do not come close to fully covering the costs of caring for the uninsured. For example, the current program established by the Department of Health and Human Services (HHS) has significant limits on which cases are eligible for coverage, and payments only are available until the funds are exhausted.

We urge Congress and the Administration to take steps to close remaining gaps in coverage. This likely does not require new coverage programs as many of the newly uninsured are already eligible for some form of subsidized program. The following steps could go a long way in expanding enrollment in health care coverage and, by extension, routine access to care:

- **Provide Employer Subsidies to Preserve Enrollment.** Many employers experiencing loss of revenue as a result of the economic downturn may choose to reduce benefits as one way to manage expenses. Congress could help employers maintain benefits by providing employer subsidies explicitly for the purposes of preserving enrollment in health coverage during the public health emergency.

- **Provide Federal Subsidies for COBRA.** The COVID-19 public health emergency has already triggered significant job loss. Many individuals may have the option to maintain their job-based health coverage through the Consolidated Omnibus Budget Reconciliation Act or COBRA but find the costs to be prohibitive, especially if they are facing a significant reduction in income, as they are expected to cover the entire cost of the monthly premium. Congress could offset the cost of coverage through COBRA to former employees through a direct subsidy or through refundable individual tax credits.
- **Provide Full Federal Match for Newly Expanding States.** Several million uninsured individuals would likely be eligible for Medicaid if the state in which they lived opted to expand Medicaid. Many of these individuals do not have access to employer-sponsored coverage and are not eligible for subsidies on the Health Insurance Marketplaces because they make too little (less than 100% of the federal poverty limit). Congress should create incentives for the remaining 14 states to expand Medicaid by providing full federal match for the first three years of expansion, regardless of when a state expands.
- **Increase Eligibility for Federal Marketplace Subsidies.** Many lower income individuals neither have access to affordable employer sponsored coverage nor are eligible for Medicaid or the Marketplaces. Congress could assist these individuals by increasing the eligibility threshold for federal subsidies for coverage through the Health Insurance Marketplaces.
- **Establish a Special Enrollment Period (SEP) for Marketplace Coverage.** While individuals who have recently lost employer-based coverage are eligible for an existing SEP, the already uninsured do not have that option. We urge the Administration or Congress to establish a new SEP specifically for those individuals who were already uninsured and not otherwise eligible for an existing SEP.
- **Prohibit Cancellation of Coverage for Non-payment of Premiums.** Insurers may disenroll individuals and families from Marketplace coverage if the enrollee is unable to pay their portion of the premium for three months. Given the economic downturn, we encourage Congress to prohibit insurers from disenrolling individuals and families from coverage for non-payment of premiums if their inability to pay their premiums is due to COVID-19-related job loss or furlough. Insurers also should be required to continue reimbursing providers for the services delivered to those individuals during this time. This prohibition should extend beyond the Marketplaces and apply to all forms of commercial coverage, including self-insured plans with the insurer bearing the cost of coverage for enrollees in self-funded plans.

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We are just beginning to understand the root causes of all the gaps in our nation's preparedness, and as such, we urge the Committee to engage with stakeholders on a regular basis to learn first-hand the reasons for the gaps and proposed solutions. There may be areas where partnerships with the private sector may be the best solution. In other areas, there may be a gap that only the government is equipped to solve. The AHA is collecting lessons learned from hospitals and health systems and will spend time analyzing potential solutions. We must be mindful of the potential benefits of proposed solutions and also of the potential unintended consequences.

The AHA is committed to working with you and Congress to improve health care system preparedness and we agree that the time to act is now. We applaud your leadership and look forward to our continued work on improving our nation's health care system preparedness.

Sincerely,

/s/

Thomas P. Nickels  
Executive Vice President