

September 25, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician 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) asks **the Secretary of Health and Human Services (HHS) to reinstate the COVID-19 Provider Relief Fund (PRF) reporting requirements outlined in your June 19 [frequently asked question](#) that defined both expenses and lost revenues attributable to COVID-19. These requirements, which stated that lost revenue was “any revenue that ... a health care provider lost due to coronavirus,” should replace those outlined in HHS’s Sept. 19 [notice](#).**

Communities rely on America’s hospitals and health systems to be strong and resilient so they can provide essential public services, particularly during emergencies and public health challenges. The PRF funds have helped them continue to put the health and safety of patients and personnel first, and in many cases, ensure they are able to keep their doors open. HHS’s Sept. 19 guidance jeopardizes this position and will come at the cost of access to care for patients and communities.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and subsequent legislation increased funding for the Public Health and Social Services Emergency Fund in order to reimburse eligible health care providers for health care-related expenses and lost revenues attributable to COVID-19. The law specified that recipients of this fund must submit reports and maintain documentation to ensure compliance with payment. As such, on June 19, HHS released a frequently asked question defining lost revenue as “any revenue that ... a health care provider lost due to coronavirus.” It stated that hospitals could “use any reasonable method of estimating the revenue during March and April 2020 compared to the same period had COVID-19 not appeared. For example, if [hospitals had prepared a budget] without taking into account the impact of



COVID-19, the estimated lost revenue could be the difference between ... budgeted revenue and actual revenue. It also would be reasonable to compare the revenues to the same period last year.” However, on Sept. 19, HHS issued a new definition of lost revenue, stating that it was “represented as a negative change in year-over-year net patient care operating income.” It specified that after covering the cost of COVID-19-related expenses, hospitals generally only will be able to apply PRF payments toward lost revenue up to the amount of their 2019 net patient operating income.

HHS’s new definition will require many hospitals to return PRF funds based on a new formula and set of metrics that are simply unfair and unrealistic. This is because the lost revenue hospitals are able to “claim” will be reduced under the new, extremely unconventional definition, as compared to HHS’s previous definition. For many, certainly, this lower lost revenue figure still will exceed their PRF payments. But for others, such as those that received substantial PRF payments and/or took aggressive and necessary steps to lower and contain costs during the pandemic, this new figure may be less than their payments, necessitating the return of funds. Many rural hospitals and those serving high numbers of low-income, elderly and severely ill patients, particularly in vulnerable communities, fall into both of these categories; as such, these already financially challenged hospitals are especially at risk for being forced to return payments. For example, one of our members, a rural safety net hospital, estimates that under the new requirements, it would be forced to return approximately \$16 million of the \$20 million it received from the PRF. Another one of our members reported that 10 of its rural hospitals would be forced to return \$20 million of the \$65 million they received from the fund. Finally, a third rural hospital member estimates that it would need to return almost 90% of its PRF funds – \$3.9 million out of \$4.5 million.

HHS made distributions to these rural hospitals for a reason – it stated that it recognized they “operate on especially thin margins,” are often in a “precarious financial position,” and are extremely “financially exposed to significant declines in revenue or increases in expenses related to COVID-19.” The Department stated that it made distributions to hospitals serving vulnerable communities because they “focus on treating the most vulnerable Americans, including low-income and minority patients, [and] are absolutely essential to our fight against COVID-19.” Forcing these and other hospitals to return many of their payments runs counter to this reasoning, and to the interest of their patients and communities. This is especially true as those hospitals must work to rebuild their capacity, while continuing to remain in a constant state of readiness for any emergencies, particularly in regard to confronting the pandemic.

While some have pointed out that claiming COVID-19-related costs, in addition to lost revenues, could allow hospitals to avoid returning funds, we do not believe this is universally accurate. Specifically, hospitals with high lost revenues are generally those in areas less affected by COVID-19; as such, they do not generally have the highest COVID-19-related costs. The inverse also applies – hospitals with high COVID-19-related costs are generally hospitals treating high numbers of COVID-19 patients; as

such, they do not generally have the highest lost revenues. Thus, if a hospital has mainly used its lost revenue to justify its PRF payments, it may not have substantial additional costs to apply to these payments.

In addition, as described above, these requirements offer a substantially different definition of COVID-19-related lost revenue than what HHS previously stated, and under which hospitals have been operating since June. This sudden shift is extremely problematic for hospitals, not only for planning and budgeting purposes, but also for accounting, auditing and bond rating purposes. It also creates a huge administrative burden. For example, hospitals that had been anticipating the retention of their PRF payments under the previous definition are now being forced to re-evaluate their conclusions under a new, extremely unconventional definition. Many of them, particularly the many hospitals with June 30 fiscal year ends, were in the final process of closing their “books.” They are now unable to do so and are scrambling to understand how this new definition affects their situation so that they can explain its implications to their auditors. Some may even be put in a position of failing their bond covenants.

In addition, so much uncertainty exists around this new definition that hospitals face the concerning prospect of having to “pay back” funds to HHS next year. While this may sound relatively simple, it would be an administrative and accounting disaster. For example, if “paying back” fiscal year 2020 income after the books have been closed leads to a revised margin for the year that is negative, a hospital’s rating with the bond rating agencies may be negatively affected. These agencies play a critical role in hospitals’ access to capital at affordable interest rates. Higher bond interest rates have a long lasting negative impact on hospitals’ financial viability.

We urge you to reinstate the June reporting requirements. Hospital and health systems throughout the nation have been relying upon the PRF distributions so that they can better withstand the staggering losses caused by this unprecedented public health crisis. Retaining these funds as entitled under HHS’s June frequently asked question will help them continue to serve the patients and communities who depend on them.

The AHA stands ready to work with HHS to resolve these issues. Please feel free to contact me or have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer