HANYS®
Always There for Healthcare

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April 2, 2020

Alex M. Azar
Secretary
Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

On behalf of the Healthcare Association of New York State and our statewide membership, we urge the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to move swiftly to directly fund hospitals and health systems with resources allocated through the Public Health and Social Services Emergency Fund as outlined by Congress in the Coronavirus Aid, Relief and Economic Security (CARES) Act.

We also urge you to consider the urgent, critical needs of hospitals throughout the state of New York that are at the forefront in responding to the COVID-19 crisis confronting our nation. To stay in the fight and win, our hospitals need financial support now.

The CARES Act increased funding for the Public Health and Social Services Emergency Fund by $100 billion to reimburse eligible healthcare providers for healthcare-related expenses or lost revenue attributable to COVID-19. Eligible providers are public entities, Medicare- or Medicaid-enrolled suppliers and providers and other for-profit and nonprofit entities as designated by the HHS Secretary.

New York state is at the epicenter of the COVID-19 pandemic, with more than 80,000 confirmed cases and nearly 2,000 deaths from the virus in less than three weeks. Our state's hospitals face enormous challenges and unprecedented strains on their resources and operations.

Hospitals statewide have invested tremendous resources to prepare for surges of patients with COVID-19. Many are already caring for significant numbers of these patients. For weeks now, hospitals have been expanding their bed capacity and purchasing supplies at higher than usual costs.

In many cases, our hospitals are taking extraordinary measures to increase staffing, including recruiting, transporting and housing personnel from other parts of the country. At the same time, all elective procedures have been halted and people are generally more inclined right now to stay home than seek non-urgent healthcare services.

These factors have limited the number of non COVID-19 patients hospitals are serving, creating serious financial challenges.

As the spread of the virus continues rapidly across the state, it is absolutely essential that New York's hospitals receive an immediate influx of funding to ensure their capacity to care for patients before, during and after the COVID-19 surge.

We urge the administration to direct the bulk of available funding to New York's hospitals and health systems, which are leading the charge against this pandemic. Prioritizing and supporting New York's effective response to COVID-19 will reduce the burden of COVID-19 response in other states throughout the country down the line and serve the greater good.

The CARES Act specified that funding be distributed on a rolling basis through "the most efficient payment systems practicable to provide emergency payment." To achieve this goal, we believe using the Medicare Administrative Contractors to process applications and make payments either to individual hospitals or to a health system for all of its hospitals is appropriate. Moreover, funding should be made available to all types of hospitals in New York, all of which are incurring expenses related to COVID-19 as they work collaboratively and cohesively to expand the capacity of the state's healthcare system.

Given the sheer magnitude of the COVID-19 pandemic, we believe the types of costs and lost revenue eligible for funds should be expansive and flexible, inclusive of those outlined by the American Hospital Association.

We request that the following types of costs and lost revenue be eligible for funding:

- Expenses related to surge capacity for COVID-19, including:
    - construction or retrofitting of infrastructure to create capacity, such as additional triage and treatment areas and command centers;
    - acquisition of equipment and supplies such as beds, ventilators, diagnostic testing supplies, personal protective equipment, pharmaceuticals and safety equipment, even if the acquired equipment and supplies are not deployed;
    - costs for setting up drive-through testing and additional screening for every patient at the entrances to hospitals and outpatient facilities;
    - acquisition of additional technology such as telehealth equipment, command center technology and software;
    - relocation of existing equipment/supplies/infrastructure to other parts of a system or the country, and the cost of leasing distribution and storage space;
    - additional security for hospitals and for temporary medical facilities; and
    - triage activities to manage the surge.

- Expenses related to ensuring an adequate workforce for COVID-19, including:
    - overtime and emergency pay for existing employees, including to create additional standby capacity;
    - salaries, benefits, overtime, emergency pay and other expenses for new/re-hired/temporary/ contract employees, including those hired to create additional standby capacity;
    - paid leave for quarantined or furloughed staff;

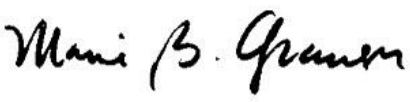
- housing costs for quarantined staff needing to self-isolate;
- hotel/housing costs for staff to enable longer work hours (e.g., through shorter commutes); and
- additional administrative expenses associated with planning, coordinating and staffing the pandemic response.

- Lost revenue attributable to COVID-19, including:
  - lost hospital revenue due to administrative directive to cancel elective procedures; and
  - lost physician/other practitioner revenue due to administrative directive to cancel elective procedures.

- Other healthcare expenses related to COVID-19, including:
  - managing and treating persons under investigation who may or may not turn out to be COVID-19-positive;
  - where needed, distributing one-time, 30-day supplies of prescriptions for acute conditions or to replace maintenance prescriptions;
  - if necessary, mortuary services;
  - purchase or lease of temporary generators for facilities that provide essential community services;
  - hotel/housing costs for discharged patients who require isolation, but cannot do so at home;
  - hotel/housing/boarding costs for discharged patients for whom placement is not (yet) possible (e.g., nursing homes refuse placement);
  - interest charged on Medicare "accelerated" or other payments;
  - interest charged on any loans taken or lines of credit extended due to the emergency; and
  - costs associated with monitoring non-hospitalized patients.

Thank you for your leadership and partnership during this challenging time. We appreciate your partnership as we work together to protect the health and well-being of the patients and communities we serve.

Sincerely,



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