American Hospital Association™
Advancing Health in America

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June 3, 2021

The Honorable Rosa DeLauro
U.S. House of Representatives
2413 Rayburn House Office Building
Washington, DC 20515

The Honorable Katie Porter
U.S. House of Representatives
1117 Longworth House Office Building
Washington, DC 20515

Dear Representatives DeLauro and Porter:

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) would like to take this opportunity to respond to your letter to Acting Federal Trade Commission (FTC) Chairwoman Slaughter and Health and Human Services (HHS) Secretary Becerra regarding your concerns about the use of Coronavirus Aid, Relief, and Economic Security (CARES) Act funds and hospital and health system integration in the wake of the COVID-19 pandemic.

At the outset, please be assured that the field very much appreciates the bipartisan congressional action that provided CARES Act and other funds to hospitals, health systems and other health care providers as the nation was being ravaged by the COVID-19 pandemic. Congress' swift response saved lives and kept hospitals struggling with unprecedented financial losses afloat during the height of the crisis. As you may recall, the very day the CARES Act was passed the nation had experienced more than 100,000 cases of COVID-19 and nearly 40,000 related hospitalizations.[i] And hospitals and health systems were not alone in being affected by the virus' onslaught. Many other providers[ii] were affected and therefore eligible for these funds, including physician practices, nursing homes and skilled nursing facilities, dentists and pharmacies, among others.

Despite Congress' generosity in providing $178 billion for hospitals and other health care providers through the CARES Act and subsequent legislation, the projected financial losses for the hospital field outstrip that amount by $145 billion in 2020 alone.[iii] Congress provided these lifesaving funds to prevent, prepare for and respond to COVID-19 and specified that funds *shall* only be used for two purposes: (1) reimbursement for health care related expenses that are attributable to COVID-19, or (2) lost revenues that are attributable to COVID-19.[iv] Considering the rapid nationwide

spread of COVID-19 last spring, Congress clearly intended to get the funds into providers' hands as rapidly as possible in order to save lives and prevent further infections.

The initial round of funds, amounting to some $30 billion, was distributed just two weeks after the CARES Act was passed using a straightforward formula that resulted in payments to some 320,000 providers – hospitals, physician practices, dentists and others – to address their *immediate* needs and those of their patients and communities.[v] Responding so swiftly required a formula that was reasonably easy to calculate and administer. Therefore, HHS chose Medicare fee-for-service reimbursements in 2019 as the basis for allocating the funds among providers. Each provider that received funds was required to attest that the payments were received and would be used in accordance with applicable terms and conditions.[vi] Moreover, the terms and conditions made it unmistakably clear that each recipient would have to provide an exact accounting for the funds when the public health emergency concluded.

To provide some context for the acceptable uses for the initial distribution the government provided guidance on what would constitute both health care related expenses and lost revenues attributable to the virus. The guidance appropriately recognized that in combating a new and, as then, poorly understood virus, providers needed some flexibility to use funds for unexpected expenses.

According to the guidance, health care expenses attributable to COVID-19 for which the funds could be used included the following:[vii]

- Supplies used to provide health care services for possible or actual COVID-19 patients;
- Equipment used to provide health care services for possible or actual COVID-19 patients;
- Workforce training;
- Developing and staffing emergency operation centers;
- Reporting COVID-19 test results to federal, state, or local governments;
- Building or constructing temporary structures to expand capacity for COVID-19 patient care or to provide health care services to non-COVID-19 patients in a separate area from where COVID-19 patients are being treated; and
- Acquiring additional resources, including facilities, equipment, supplies, health care practices, staffing and technology to expand or preserve care delivery.

Lost revenues could include any revenue lost due to COVID-19, including lost revenue from:[viii]

- Fewer outpatient visits;
- Canceled elective procedures or services; or

- Increased uncompensated care.

Furthermore, the guidance encouraged providers to use funds covering lost revenue to respond to the public health emergency by maintaining health care delivery capacity, such as:

- Employee or contractor payroll;
- Employee health insurance;
- Rent or mortgage payments;
- Equipment lease payments; and
- Electronic health record licensing fees.

The initial distribution provided the breathing space the hospital and health system field needed to prepare for and/or respond to surges in infected patients. It also gave the government time to assess the field's needs and those of other health care providers. To that end, subsequent distributions were more targeted. The chart below described those distributions, including the methodology to determine the allocations:[ix]

Summary of Eligibility & Methodology

Phase 1 General Distribution	
Distribution & Eligibility	Formulas to Determine Allocation
Initial $30 billion Automatic based on provider's share of Medicare fee-for-service reimbursements in 2019	Payment Allocation per Provider = (Provider's 2019 Medicare Fee-For-Service Payments / $453 Billion) x $30 Billion
Additional $20 billion Based on CMS cost reports, submitted revenue information, or incurred losses	Payment Allocation per Provider = ((Most Recent Tax Year Annual Gross Receipts x $50 Billion) / $2.5 Trillion) – Initial General Distribution Payment to Provider
Phase 2 General Distribution	
Distribution & Eligibility	Formulas to Determine Allocation
$18 billion Providers who participate in state Medicaid/CHIP programs, Medicaid	Payment Allocation per Provider **=** 2% (Revenues **x** Percent of Revenues from Patient Care)*

<table>
<tr><th colspan="2">Phase 2 General Distribution</th></tr>
<tr><td>managed care plans, or provide dental care, as well as certain Medicare providers, including those who missed Phase 1 General Distribution payment equal to 2% of their total patient care revenue or had a change in ownership in 2019 or 2020</td><td>*Most recent tax filings (CY2017, 2018, or 2019)</td></tr>
<tr><th colspan="2">Targeted Distribution</th></tr>
<tr><td>Distribution & Eligibility</td><td>Formulas to Determine Allocation</td></tr>
<tr><td rowspan="2">High-Impact Distribution

First Round
Hospitals with 100 or more COVID-19 admissions between January 1 and April 10

Second Round
Hospitals with over 160 COVID-19 admissions between January 1 and June 10, 2020, or the facility experienced an above average intensity of COVID admission per bed (at least 0.54864)</td><td>First Round

$10 Billion to 395 High-Impact Hospitals

Payment Allocation per Hospital = Number of COVID-19 Admissions* x $76,975

$2 Billion to 395 High-Impact Hospitals with Medicare Disproportionate Share

Additional Payment Allocation per Hospital = $2 Billion x (Hospital Medicare Funding / Sum of Medicare Funding for 395 Hospitals)</td></tr>
<tr><td>Second Round

$10 Billion to more than 1,000 High-Impact Hospitals

Payment Allocation per Hospital = Number of COVID-19 Admissions x $50,000</td></tr>
</table>

Targeted Distribution	
	(HHS also took into account previous High Impact Area payments for those hospitals that received initial payments from this Targeted Distribution.)
Rural Distribution Based on operating expenses and type of facility	**Rural Acute Care Hospitals and Critical Access Hospitals** Payment Allocation per Hospital **=** Graduated Base Payment* **+** 1.97% of the Hospital's Operating Expenses **Base payments ranged between $1 million to $3 million.* **Rural Health Clinics (RHC)** Payment Allocation per Independent RHC **=** $100,000 per clinic site **+** 3.6% of the RHC's Operating Expenses **Community Health Centers (CHC)** Payment Allocation per CHC **=** $100,000 per rural clinic site **Sole Community Hospitals (SCH), Medicare Dependent Hospitals (MDH), & Rural Referral Center (RRC) Hospital in Small Metro Areas** Payment Allocation per Hospital **=** 1% of operating expenses* ** Minimum payment of $100,000, a supplement of $50 for each rural inpatient day, and a maximum payment of $4.5 million.*

Targeted Distribution	
	HHS also provided a supplemental payment of $1,000,000 for 10 isolated urban hospitals that are 40 or more miles away from another hospital open to the public. **Small Metro Area Hospitals without a special Medicare designation** Payment allocation per Hospital **=** 1% of operating expenses* * *Minimum payment of $100,000 and a maximum of $2 million each.* **Rural Specialty Hospitals** Payment Allocation per Hospital **=** Graduated Base Payment* **+** 1.97% of the Hospital's Operating Expenses* **Minimum payment of $100,000 and a maximum of $4.5 million.*
Allocation for Skilled Nursing Facilities (SNFs) Certified SNFs with six or more beds	$4.9 Billion Distribution: Payment Allocation per facility **=** Fixed Payment of $50,000 **+** $2,500 per bed $2.5 Billion distribution: Payment Allocation per-facility= Fixed payment of $10,000 + $1,450 per bed
Allocation for Indian Health Service (IHS) Based on operating expenses	**IHS and Tribal Hospitals** Payment Allocation per Hospital = $2.81 Million + 2.58% of Total Operating Expenses **IHS and Tribal Clinics and Programs**

Targeted Distribution	
	Payment Allocation per Clinic/Program = $187,500 + 5.43% (Estimated Service Population x Average Cost per User) **IHS Urban Programs** Payment Allocation per Program = $181,250 + 6.25% (Estimated Service Population x Average Cost per User)
Allocation for Safety Net Hospitals **Acute Care Facilities** A Medicare Disproportionate Payment Percentage (DPP) of 20.2% or greater, annual uncompensated care (UCC) per bed of $25,000 or more, and a profit margin of 3% or less Certain acute care hospitals serving vulnerable populations with profit margins averaging less than 3% as reported to the Centers for Medicare and Medicaid Services (CMS) **Children's Hospitals 1** A Medicaid-only ratio of 20.2% or greater and a profit margin of 3% or less **Children's Hospitals 2** Qualifying free-standing children's hospital must either be an exempt hospital under the Centers for Medicare and Medicaid Services (CMS) inpatient prospective payment system (IPPS) or be a HRSA defined Children's Hospital Graduate Medical Education facility. *HHS expects most non-free-standing children's hospitals should have received financial support from their*	**Acute Care Facilities and Children's Hospitals 1** Payment Allocation per Hospital **=** (Hospital's Facility Score* ***/*** Cumulative Facility Scores across All Safety Net Hospitals) **x** $10 Billion **Facility Score* ***=*** *Number of facility beds* ***x*** *DPP for acute care facility or number of facility beds* ***x*** *Medicaid-only ratio for a children's hospital* **Children's Hospitals 2** Payment Allocation per Hospital **=** 2.5% of Net Revenue from Patient Care

Targeted Distribution	
parent hospital systems as a share of General Distributions payments from the Provider Relief Fund program.	

We expect that the funds remaining will be allocated based on demonstrated need. **One thing is clear, following the initial emergency distribution, funds have been directed to those sectors in health care determined to be in need of them.** The other things that are clear are that recipients of any of these funds must report on how the funds were used for the congressionally-specified purposes and return any unused funds to the Department of the Treasury.[x]

Throughout the pandemic (which continues today), hospitals and health systems faced enormous challenges. To date, hospitals and health systems have admitted more than 1.78 million patients with COVID-19 and cared for countless more in outpatient settings. In addition to caring for surges of infected patients, protecting their caregivers, and supporting their community, many hospitals and health systems were impressed into service to backstop inadequate public health efforts. Here are just a few examples of how hospital systems responded to these challenges:

- BJC HealthCare, an integrated system with 14 hospitals serving metropolitan Saint Louis and surrounding states, purchased large quantities of the personal protective equipment that was in such short supply at the pandemic's inception. Not only did that purchase help to keep its own staff safe, it allowed the health system to adequately prepare for a surge of COVID-19 patients and protect those patients who did not have the virus. When vaccines became available, BJC deployed vans and established clinics throughout the area in order to reach deep into the diverse neighborhoods it serves.

- Spectrum Health, an integrated health system in Michigan with 14 hospitals, a medical group and a health plan serving more than 1 million members, developed and launched regular communications to educate its team members, communities and partners about COVID-19. These included virtual town halls, video calls and comprehensive online resources with translations for non-English speakers.

- Atrium Health, an integrated system with 37 hospitals serving the Carolinas and Georgia, formed a unique public-private partnership that included Honeywell and Charlotte Motor Speedway to provide 1 million doses of the COVID-19 vaccine by July 1. Hundreds of Atrium's physicians, advanced practice providers and

> other employees volunteered their personal time to make this mass vaccination effort a success.[xi]

It also is important to recognize that integrated health systems, like those referenced above, ensured the survival of some of the community and rural hospitals that otherwise would have succumbed to the pandemic's often overwhelming medical, workforce and financial challenges. Even before the pandemic began, "about one in five hospital partnership transactions involved a financially distressed hospital, many at risk of imminent closure."[xii] Some 137 rural hospitals closed their doors since 2010 and 19 closed last year; more might have closed without the lifeline integration provided.

Not only does integration have demonstrated benefits for patients and communities, but much of the information that would suggest otherwise is seriously flawed.[xiii] Two transactions in the state of Connecticut provide typical examples of the benefits of integration to patients and communities. Not only do they illustrate that quality improves, wages rise and career opportunities open up but also that innovation, investments in infrastructure, equipment and technology and access for patients and communities increases.[xiv] And recent studies by Charles River Associates[xv] show integration provides these benefits without increasing revenues – a finding entirely inconsistent with suggestions that integration increases the market power of health systems over commercial health insurers.

Often ignored in hospital integration discussions is the impact on consumers of consolidation among the commercial health insurance industry. Numerous studies, including the American Medical Association's, show not only a steady progression of consolidation among commercial health insurers to 74% of metropolitan statistical areas, but that it is insurer consolidation that is primarily responsible for increased premium prices.[xvi] And an influential court case challenging additional consolidation among commercial health insurers revealed that despite promises otherwise, it is likely rare for those insurers to pass on any of the benefits of lower costs from hospitals to consumers.[xvii] And a more recent case illustrated the lengths commercial insurers will go to prevent competition from others, including integrated health systems, to maintain their leverage over hospitals and health systems.[xviii]

The fact is during the worst of the pandemic, which consumed most of last year, hospitals' and health systems' attention was firmly rooted on healing patients, keeping staff safe, maintaining staffing levels, reconfiguring services to keep patients without the virus safe, assuring their communities had the best information about how to stay safe and avoid contracting the virus, preparing for the rollout of vaccines, administering the vaccines, and hundreds of other priorities. Not surprisingly, hospital merger activity was down last year[xix]. What did increase was the desperate need for staff, particularly trained nurses, who were in such short supply that some nurse staffing agencies were charging triple for their services.[xx]

Lastly, you can be assured that any merger activity that raises competitive issues at any time will be scrutinized closely by the FTC and state attorneys general. While the AHA has frequently been critical of the FTC's approach and framework to assess hospital transactions, we are aware that the agency continues to challenge any transaction it believes presents anticompetitive risks. And, the FTC has *many* tools to discourage hospitals from moving forward with a transaction before it even gets to court, which reportedly it employs liberally.

We hope that you find this information to be useful and if you would like discuss these or other issues further, we would be pleased to do so. You can contact me or Stacey Hughes, AHA executive vice president, at shughes@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

CC: The Honorable Xavier Becerra, Secretary of the Department of Health and Human Services
The Honorable Rebecca Kelly Slaughter, Acting Chairwoman of the Federal Trade Commission

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[i] These numbers are likely an undercount of the cumulative cases and hospitalization as COVID-19 testing was not widely available and data collection was not yet reliable. By the end of 2020, there were a total of 18,891,286 reported cases of COVID-19 and 1,119,680 related hospitalizations according to the CDC.

[ii] AHA's best estimate is that hospitals received approximately 56% of the funds to date. Funds were available to other providers of health care, services, and support in a medical setting, at home, or in the community, including, but not limited to: acute care hospitals, ambulatory surgical centers, assisted living facilities, behavioral health providers (e.g., substance use disorder, counseling, psychiatric services), dental services, diagnostic services (e.g., independent imaging, radiology, labs), DME/suppliers, eye and vision services, home and community-based support (e.g., housing services, care navigators, case management), home health agencies, inpatient behavioral facilities (e.g., inpatient rehabilitation facilities, long-term acute care hospitals, other residential facilities), multi-specialty practices, nursing homes and skilled nursing facilities, other ancillary services (e.g., chiropractors, speech and language pathologists, physical therapy, occupational therapy), other inpatient facilities, other outpatient clinics (e.g., urgent care, dialysis center), other services (e.g., foster care, developmental disability services), other single-specialty practices, pediatrics practices, pharmacies (Note: Prescription sales revenue may not be reported as part of revenue from patient care), and primary care practices. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/for-providers/index.html.

[iii] AHA analysis of American Hospital Association (June 2020), "Hospitals and Health Systems Continue to Face Unprecedented Financial Challenges due to COVID-19" and U.S. Department of Health and Human Services, "CARES Act Provider Relief Fund." Accessed on May 27, 2021: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html

[iv] CARES Act, Public Law No. 116-136. The appropriation in Division B, Title VIII to the Public Health and Social Services Emergency Fund to support hospitals and health care providers, repeated in subsequent legislation appropriating additional funds, states as follows: "for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus."

[v] Two weeks after enactment of the CARES Act, on April 10, 2020, HHS distributed $30 billion to eligible providers who billed Medicare fee-for-service in order to provide financial relief during the coronavirus (COVID-19) pandemic. An additional $16 billion was later distributed. These funds were allocated proportional to providers' share of annual patient revenue. https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#phase1

[vi] Each provider who receives Provider Relief Fund distributions must attest that it will meet the terms and conditions for the distribution. Those terms and conditions track the language of the appropriation statute and read as follows: "The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus."

[vii] CARES Act Provider Relief Fund FAQs, question and answer added June 2, 2020. The General and Targeted Distribution Post-Payment Notice of Reporting Requirements, dated January 15, 2021, continues to treat these expenses and many others as health care expenses attributable to coronavirus.

[viii] Id.

[ix] https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#phase1. Content created by Assistant Secretary for Public Affairs (ASPA) Content last reviewed May 25, 2021

[x] We are aware that some hospital systems have already returned funds to the Treasury that they did not believe could be used for the congressionally specified purposes.

[xi] There are more examples of hospitals and hospital systems stepping into the breach at: https://www.aha.org/bibliographylink-page/2018-04-20-value-hospital-mergers

[xii] https://www.fiercehealthcare.com/hospitals/industry-voices-a-time-need-hospitals-must-be-able-to-transform

[xiii] See AHA testimony: "Antitrust Applied: Hospital Consolidation Concerns and Solutions," May 19, 2021 https://www.aha.org/testimony/2021-05-19-aha-testimony-antitrust-applied-hospital-consolidation-concerns-and-solutions

[xiv] Panel: Milford hospital has 'significant improvements' since 2019 merger, with millions invested By Saul Flores, CT Post/Milford Mirror/NH Register (5/14/21) and https://www.aha.org/case-studies/2021-06-02-yale-new-haven-hospital-saint-raphael-integration-progress-review

[xv] Charles River Associates is the same economics consulting firm that the current and past two California Attorneys Generals used in connection with their challenges to hospital integration, *e.g.*, https://www.aha.org/2021-05-28-amicus-brief-pasadena-hospital-assn-ltd-dba-huntington-hospital-and-cedars-sinai-health
https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits

[xvi]ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas With More Competition HEALTH AFFAIRS 37, NO. 8 (2018): 1243–125 and https://www.ama-assn.org/system/files/2020-10/competition-health-insurance-us-markets.pdf.

[xvii] From the district court decision in United States v Anthem Inc Feb. 8, 2017: "First of all, there is reason to doubt that the claimed savings will be entirely passed on to consumers as Anthem has repeatedly assured the Court that they would. See Curran (Def. Counsel) Tr. 40 (opening statements) ("As to the medical cost savings, those are guaranteed to flow through to the ASO customers.") (Anthem's internal documents reflect that the company has been actively considering multiple scenarios for capturing any medical cost savings for itself….)".

[xviii]From the decision: "While IBC and Einstein were negotiating a new contract, IBC invited Einstein's President and CEO, Barry Freedman, to an Eagles game. See (id. (Freedman) at 131:13-25). At halftime, IBC's CEO and another executive told Freedman that IBC would terminate its contract with Einstein if Einstein partnered with UPMC. UPMC wanted to bring Einstein together with a managed care company so that UPMC could enter the southeastern Pennsylvania market as both a provider and an insurer. The case is Federal Trade Commission v. Thomas Jefferson University et al., case number 2:20-cv-01113, in the U.S. District Court for the Eastern District of Pennsylvania.

[xix] There were 79 deals announced in 2020 compared to a five-year average of 89.6 per year (2015-2019). (Irving Levin Associates, Inc. (2021). The Health Care Services Acquisition Report, Twenty-Seventh Edition, 2021).

[xx] This is an excerpt from a letter from AHA to FTC, to which AHA has never received a reply: "A recent article in *Modern HealthCare*, which is attached, confirmed that the demand these agencies are seeing for travel nurses is 'unprecedented in their company histories.' While many hospitals were reluctant to supply *Modern* with information on the enormous rate hikes from these agencies for fear of retribution, the article reported that rates for travel nurses in some instances had tripled."
https://www.aha.org/lettercomment/2021-02-04-aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-and