GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

April
Six
2 0 2 0

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

Dear Secretary Azar:

I am writing to follow up on my March 30 letter to you requesting a distribution for New York hospitals from the $100 billion Public Health and Social Services Emergency (PHSSE) Fund in the CARES Act. I emphasize the severe financial impact that the COVID-19 response is having on hospitals and health systems in New York, particularly those in the New York City metropolitan area that is the epicenter of COVID-19 cases. Our thinking on a rational funding allocation methodology is described below.

New York State currently has nearly 16,500 hospitalized COVID-19-positive patients, of which nearly 4,000 are intubated. This is driving New York State's health care system, particularly in the downstate region that has 90% of the total COVID-19 patient load, to the breaking point.

Financial Impacts
The major health systems in the New York City metropolitan area currently estimate a **$350 million per month impact** from their Covid-19 response efforts. This is primarily the result of lost revenue from the cancellation of elective procedures and services, increased staffing and overtime costs from bringing in agency nurses and backfilling for quarantined staff, as well as increased pharmaceutical, supply, and equipment costs to retrofit spaces and build temporary structures meet the patient care surge need for COVID-19 patients. By any measure, these astronomical numbers will have a long-term impact on the health care system if they are not significantly mitigated.

Proposal for Distributing $100 Billion PHSSE Fund
GNYHA proposes that the PHSSE fund be distributed to hospitals in two phases:

Phase 1: Initial Formula-Based Distribution
Funding should be prioritized for hospitals in "hot spot" areas. We define these as locations with confirmed cases/100,000 and/or deaths/100,000 is greater than the national average plus one standard deviation. We have identified 16 high-priority regions as of April 1. The attached document identifies the regions and describes a proposed methodology. The areas will change over time, and as permitted under the CARES Act, HHS could provide additional hot spot payments in additional funding rounds.

If a decision is made to provide funding to a broader set of hospitals, including those located in non-hot spot regions, the distributions must take into account regional differences in purchasing power and other exogenous factors that cause differences in treatment costs.

Phase 2: Expense/Lost Revenue-Based Distribution
Phase 2 distribution should be reserved for hospitals that have significant financial impacts from treating COVID-19 patients, including increased operating expenses and lost revenues from the cancellation of

non-emergent services. This funding should be distributed through an application-based approach—potentially through the Medicare Administrative Contractors or other entity—and again, hospitals in the hardest-hit areas should be prioritized. The application would provide a proportionate share of the remaining funding for eligible applicants, net of any funding provided in Phase 1 described above.

Thank you for your continued collaboration during this challenging time for the health care system.

My best.

Sincerely,

Kenneth E. Raske
President

cc: Governor Andrew Cuomo
Senator Chuck Schumer

PRESIDENT, KENNETH E. RASKE • 555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG

Initial Distribution to Hospitals for COVID-19 Relief

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provided $100 billion for health care providers to cover their expenses for treating COVID-19 patients and their revenue losses associated with canceling elective hospital admissions and other services.

GNYHA has developed the following key principles:

- Any funding provided on a broad basis must be appropriately adjusted for regional differences in purchasing power and other exogenous factors that cause variation in treatment costs.
- Funding must be targeted to hospitals located in "hot spots" on a rolling basis to address immediate financial challenges.

Formula-based Distribution to Hospitals

If a decision is made to provide all U.S. hospitals with a short-term funding distribution, we believe it is necessary to adjust any relief payments to control for exogenous causes of variation in treatment costs, including geographic variation in purchasing power, indirect medical education (IME) costs, and disproportionate share hospital (DSH) costs. Finally, we believe if all hospitals receive a basic relief payment, hospitals located in current COVID-19 hot spots should receive an additional hot spot payment.

The attached appendix describes the methodology we recommend for deriving basic relief payments and hot spot payments. In summary, that method would derive basic relief payments by adjusting a national amount per bed by a geographic adjustment factor (GAF) for all beds and by an IME and DSH adjustment for acute care beds at inpatient prospective payment system (IPPS) hospitals. We would apply the pre-reclassification GAF, cost-of-living adjustment (COLA), IME, and DSH adjustments in the capital PPS because those are empirical adjustments that were developed to apply to combined operating and capital IPPS payments. We would apply the capital PPS GAFs and COLAs to relief payments for exempt unit and exempt hospital beds as well as for acute care beds in IPPS hospitals.

Hot Spot Payments

Regarding hot spot payments, we would restrict them to acute care beds in IPPS hospitals located in metropolitan statistical areas (MSAs) and statewide rural areas with COVID-19 cases per 100,000 population at or above the national mean plus one standard deviation. Then, for hospitals in qualifying MSAs and rural areas, we would derive hot spot payments by multiplying hospital-specific base payments by a regional hot spot multiplier. The hospital-specific base payments would be a significant incremental dollar amount per acute care bed, adjusted to control for GAF, COLA, IME, and DSH costs. And the hot spot multiplier would each MSA or rural area's COVID-19 rate divided by the national threshold, which, again, would be the national mean plus one standard deviation.

As of April 1, 2020, IPPS hospitals in the following 16 MSAs would qualify for hot spot payments. The table shows the national COVID-19 threshold rate, each area's COVID-19 rate, and each area's hot spot multiplier, which is the index of its COVID-19 rate to the national threshold. Future funding rounds could be provided to hospitals located in other regions based on the identification of future "hot spots."

Code	MSA	COVID-19 Cases/100k	Index = Hot Spot Multiplier
	Threshold = national mean + 1 stdev.	119.63	-
35004	Nassau County-Suffolk County, NY	605.61	5.06
35614	New York-Jersey City-White Plains, NY-NJ	579.21	4.84
10500	Albany, GA	448.45	3.75
35380	New Orleans-Metairie, LA	346.31	2.89
39100	Poughkeepsie-Newburgh-Middletown, NY	339.10	2.83
19804	Detroit-Dearborn-Livonia, MI	255.52	2.14
35084	Newark, NJ-PA	239.73	2.00
14860	Bridgeport-Stamford-Norwalk, CT	210.53	1.76
35154	New Brunswick-Lakewood, NJ	188.03	1.57
20700	East Stroudsburg, PA	163.27	1.36
14454	Boston, MA	148.34	1.24
38340	Pittsfield, MA	146.47	1.22
28740	Kingston, NY	125.02	1.05
42644	Seattle-Bellevue-Kent, WA	123.65	1.03
47664	Warren-Troy-Farmington Hills, MI	122.48	1.02
12700	Barnstable Town, MA	119.72	1.00

Appendix

Basic Relief Payments

Adjustment to Relief Payments for Exempt Units and Hospitals

It is necessary to adjust relief payments by geographic adjustment factors (GAFs) to ensure purchasing power parity. The following method is recommended:

1. For each of the roughly 6,000 hospitals, obtain the county in which it is located from Worksheet S-2 of the Medicare cost reports.
2. Based on the latest county definitions of core-based statistical areas, map each urban county to its applicable metropolitan statistical area or metropolitan division (MSA), and map other counties to their statewide rural areas.
3. Based on the corrected hospital-specific hours and occupational mix-adjusted wages found on the website for the inpatient prospective payment system (PPS) final rule for federal fiscal year 2020, derive an area wage index for each urban and rural area.
4. To convert the area wage indices into geographic adjustment factors (GAFs), apply the method in the capital PPS because it was developed to apply to combined operating and capital costs:
    a. Raise each wage index to the power of 0.6848.
    b. Derive an average of cost-of-living adjustment (COLA) for each urban and rural area in Alaska and Hawaii and assign a COLA of 1.000 to all other urban and rural areas.
    c. Multiple the two adjustments to derive an applied GAF for each MSA and rural area.

Adjustment to Relief Payments for Acute Care Beds in Non-Exempt Hospitals

For acute care beds in hospitals reimbursed under the inpatient prospective payment system (IPPS), it is necessary to adjust relief payments by the GAFs described above and by the IME and DSH adjustments in the capital PPS because these adjustments control for other exogenous factors that cause variation in hospital treatment costs.

Bed Counts

Derive each hospital's bed count(s) as follows:

1. Based on the Provider Reimbursement Manual, identify each hospital as Inpatient PPS (IPPS) or Non-IPPS based on the last four digits of its CMS certification number (CCN).
2. Based on Worksheet S-3, Part I, of the Medicare Cost Reports, identify each cost center as either Acute Care, Non-Acute, or Not Applicable.
3. For Non-IPPS hospitals, identify all applicable reported beds and staffed beds (bed days available divided by 365 days) as Non-Acute.
4. For IPPS hospitals, separately identify all applicable beds as Acute Care or Non-Acute.
5. Sum each hospital's Acute Care and Non-Acute reported beds and staffed beds and apply the higher of the reported beds or staffed beds.

Adjusted Relief Payments

Derive a basic relief payment per bed for each hospital as follows:

- For all Non-IPPS beds and the Non-Acute beds of IPPS hospitals, the basic relief payment amount multiplied by the GAF.
- For the Acute Care beds of IPPS hospitals, the relief payment is a base amount multiplied by the product of the GAF and the sum of one, the capital IME adjustment, and the capital DSH adjustment.

Total basic relief payments are the sum of Non-Acute beds multiplied by the Non-Acute relief payment per bed and Acute Care beds multiplied by the Acute relief payment per bed.

Hot Spot Payments

Hot Spot payments should be restricted to Acute Care beds at IPPS hospitals located in MSAs or rural areas that have COVID-19 cases per 100,000 population at or above a Hot Spot threshold, where the threshold be the national mean plus one standard deviation. Hot Spot payments should be calculated as the product of a hospital-specific payment and a regional Hot Spot Multiplier, where:

- The hospital-specific payment would be multiplied by the product of the GAF and the sum of one, the capital IME adjustment, and the capital DSH adjustment.
- The regional Hot Spot multiplier is an index of each eligible MSA or rural area's COVID-19 rate to the Hot Spot threshold.

Derivation of Regional Hot Spot Multipliers

To derive each MSA and rural area's COVID-19 rate, obtain county-level population data from the Census Bureau and the latest county-level COVID-19 cases from *The New York Times'* link to www.github.com or another source. Then aggregate each county's population and COVID-19 cases to the MSAs and statewide rural areas and derive each MSA and rural area's COVID-19 cases per 100,000 population.

As of April 1, 2020, the national mean COVID-19 rate was 63 cases per 100,000 and the standard deviation was 56 cases per 100,000. Therefore, the Hot Spot threshold would be 120 cases per 100,000. The following table shows the 16 MSAs that would qualify for a Hot Spot payment per Acute Care bed, along with each MSA's COVID-19 cases per 100,000 population and the index of each MSA's rate to the eligibility threshold, which would be its Hot Spot Multiplier.

Code	MSA	COVID-19 Cases/100k	Index = Hot Spot Multiplier
	Threshold = national mean + 1 stdev.	119.63	-
35004	Nassau County-Suffolk County, NY	605.61	5.06
35614	New York-Jersey City-White Plains, NY-NJ	579.21	4.84
10500	Albany, GA	448.45	3.75
35380	New Orleans-Metairie, LA	346.31	2.89
39100	Poughkeepsie-Newburgh-Middletown, NY	339.10	2.83

Code	MSA	COVID-19 Cases/100k	Index = Hot Spot Multiplier
19804	Detroit-Dearborn-Livonia, MI	255.52	2.14
35084	Newark, NJ-PA	239.73	2.00
14860	Bridgeport-Stamford-Norwalk, CT	210.53	1.76
35154	New Brunswick-Lakewood, NJ	188.03	1.57
20700	East Stroudsburg, PA	163.27	1.36
14454	Boston, MA	148.34	1.24
38340	Pittsfield, MA	146.47	1.22
28740	Kingston, NY	125.02	1.05
42644	Seattle-Bellevue-Kent, WA	123.65	1.03
47664	Warren-Troy-Farmington Hills, MI	122.48	1.02
12700	Barnstable Town, MA	119.72	1.00