

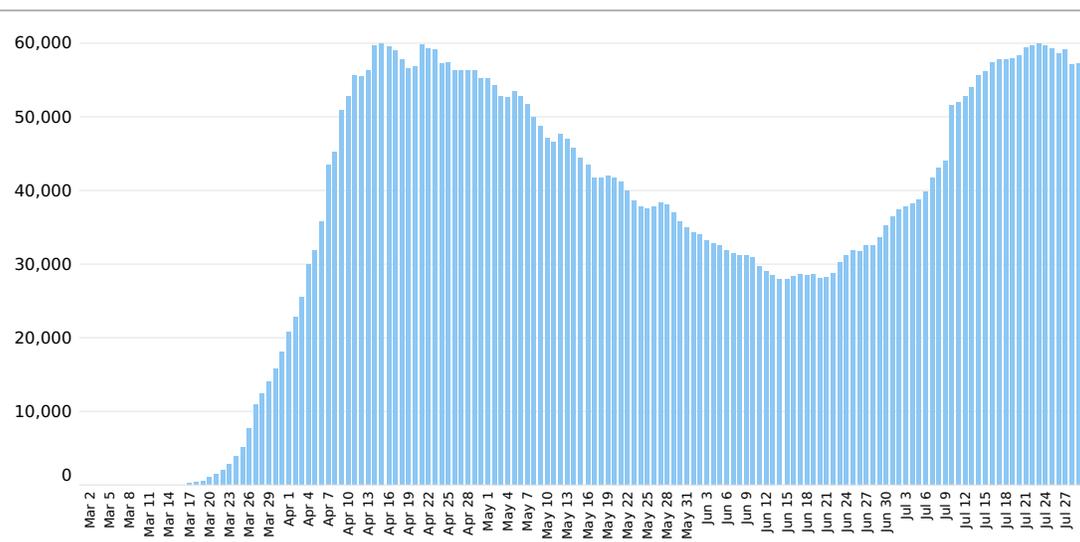
Hospitals on the Front Line as COVID-19 Surges, Medicare Payments Withheld

As COVID-19 cases continue to surge across the United States, the pandemic remains a threat to the financial viability of frontline hospitals and their ability to care for patients across our nation. In the early months of the outbreak, increased costs associated with preparing for and treating acutely ill COVID-19 patients, combined with reduced revenues, led many providers to financial peril. In late March and early April, the Trump Administration, backed by Congressional action, advanced Medicare payments for up to six months under the Medicare Accelerated and Advance Payment Program (MAAPP), a policy intended to alleviate the financial pressure on hospitals as the outbreak upended health care across the country. For many hospitals, the 120-day deadline to begin repaying the borrowed funds has now arrived – even though the pandemic is just now peaking in many parts of the country and there is no end in sight for its impact on their operations and finances. COVID-19 hospitalizations are on the rise, and struggling hospitals face a doomsday scenario, particularly in rural areas. Unless Congress acts swiftly to delay the repayment deadline and amend the repayment terms, many hospitals battling COVID-19 will see their Medicare payments cease entirely as funds are recouped by the federal government.

COVID-19 shows no signs of abating as cases and hospitalizations increase nationwide, particularly in rural areas. MAAPP was designed to sustain providers and ensure access to care for the pandemic’s duration. When the program launched, the U.S. outbreak was concentrated primarily in certain cities, and many anticipated that it would subside by summer. Instead, COVID-19 is spreading, devastating Americans everywhere, from big cities in Texas to small towns in rural North Carolina.¹ On July 30, the U.S. reported over 65,000 new COVID-19 cases,² nearly double the daily numbers reported in early April.³ Based on current projections,⁴ the resulting strain on hospital capacity and finances could persist well into 2021.

US CURRENTLY HOSPITALIZED WITH COVID-19

Mar 1 to Jul 30



Note: Florida began reporting this figure on July 10.

Source: <https://covidtracking.com/data/charts/us-currently-hospitalized>

Hospitals Remain on the Front Lines

Since the outbreak of the novel coronavirus, hospitals in the U.S. have dedicated unprecedented emergency resources to combatting COVID-19, from preparedness efforts to the treatment of the acutely ill. Hospitals remain committed to this cause, but they need a sustainable path forward with policies that help, not hinder their already perilous financial situation.

- At the start of the pandemic in March, over 18 million Americans lived in counties with no intensive care units (ICUs), many in rural and underserved areas. Hospitals across the country met the challenge of expanding capacity, building new ICUs, and converting existing spaces at considerable cost.⁵
- When the anticipated surge of COVID-19 patients arrived, hospitals were prepared – having procured ventilators and personal protective equipment (PPE), increased staffing of ICUs, and converted space for critical care. These changes required resource investments long before COVID-19 patients reached those hospitals’ doors. According to Jeffrey Smith, MD, Center Chief Operating Officer of Cedars-Sinai Medical center in Los Angeles, **the cost of “converting a regular ward bed into an ICU bed costs up to \$45,000 for equipment alone.”**⁶
- The Peninsula Regional Medical Center in Salisbury, Maryland established two new intensive care units to gain additional capacity of inpatient medical and surgical beds. The new, larger ICUs contain up to 48 beds and up to 60 ventilators and were converted from existing office space and other treatment units. **The estimated cost for both ICUs: \$3.8 million.**⁷
- In Texas, rural hospitals are already in the red and, according to Haskell Memorial Hospital CEO Chris Strickland, continue to contend with an increase in prices for PPE amid rising demand, one of many preparedness challenges they face.⁸

Rural Hospitals Bear the Brunt

The pandemic has placed an untenable strain on hospitals in rural communities that were already struggling to keep their doors open. Rural communities need access to life-saving services as these residents are particularly at high-risk.

- The Centers for Disease Control (CDC) notes that rural communities face higher risks during the COVID-19 pandemic. Rural Americans are likelier to be older and suffer from chronic disease, two key risk factors for COVID-19.⁹
- A study by the Chartis Group found that 63 percent of the nation’s rural hospitals lack any ICU beds. In 20 states, the percentage of rural hospitals without ICU beds is at least 66 percent.¹⁰
- In regions where COVID-19 cases and hospitalizations are surging, hospitals in some areas of the country are once again being forced to cancel scheduled, non-emergency procedures, including parts of Florida, Alabama, Texas, and Arizona, cutting off an essential revenue source.¹¹
- Most rural hospitals have limited cash on hand to continue operating in the event of an emergency. Nationally, the median cash on hand at rural hospitals would cover just 33 days of expenses.¹²
- After overcoming bankruptcy less than two years ago, one Mississippi hospital today finds itself back in the red and on the brink after a COVID-19-related increase in uncompensated care and the \$81 million spent on COVID-19 related costs.¹³
- A record 47 hospitals closed their doors in 2019. 2020 is on track to break that record. As of late-June, 42 U.S. hospitals have either closed or filed for bankruptcy.¹⁴
- Rural hospitals comprise many of those closures. According to data from the University of North Carolina at Chapel Hill, 12 rural hospitals have already closed this year. Several of these closures were in states that are now COVID-19 hot-spots, including Florida and Texas.¹⁵
- For hospitals that do not experience an influx of COVID-19 patients, the cost of ongoing preparedness while overall patient volume declines is especially devastating. Rural hospital occupancy is tied closely to overall operating margins, and the cost of preparing to care for patients who do not materialize threatens financial viability.¹⁶

The sustained effects of the COVID-19 pandemic on hospitals, particularly in rural areas, are significant and ongoing. Reexamining the repayment terms of the MAAPP program is critical to ensuring that hospitals are financially viable and have the resources necessary to provide high quality care to patients in their communities.

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