

## Supporting Hospitals During a New Wave of COVID-19

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The COVID-19 pandemic has put an extraordinary strain on US hospitals.<sup>1</sup> In spring 2020, many hospitals had to quickly adapt to treat a surge of patients, and many more had to prepare for a potential surge. Creating reserve capacity meant halting outpatient care and elective surgeries, repurposing inpatient units, and increasing critical care staffing. Hospitals again face these difficult decisions, as COVID-19 resurges and variants of SARS-CoV-2 increasingly circulate, with large financial losses projected for 2021.<sup>2</sup> Some large hospital systems may have the financial reserves to weather this storm, but the precarious situation facing others likely requires policy action.

Hospitals' financial stress emanates from multiple quarters. First, revenue from elective inpatient procedures and outpatient care dropped dramatically, has not fully rebounded,<sup>3,4</sup> and is not fully offset by revenue from COVID-19 care. Second, high unemployment may force up to 20% of commercially insured Americans into lower-reimbursing public insurance or the ranks of the uninsured, generating a projected \$95 billion annual loss for hospitals.<sup>5</sup> Third, under the current payment system, the costs of preparing for a pandemic are not directly reimbursed. Yet—whether or not they ultimately experienced a large COVID-19 caseload—hospitals' surge preparation has involved purchasing vast quantities of protective personal equipment (PPE) and other supplies and equipment, hiring additional staff, building SARS-CoV-2 testing capacity, and expanding occupational health services. Many expenses persist as “the new normal”: admissions now require SARS-CoV-2 testing, additional staff and PPE, and often, a private room. Physical distancing requirements mean hospitals' capacity—and thus, revenue—will remain reduced.

Private insurers, by and large, are not volunteering to cover these increased costs, and it is difficult for hospitals to pass them along. Payment terms in many contracts (eg, for Medicare) are not modifiable; even where they are, renegotiating takes time. To date, federal relief payments from the CARES Act do not fully reimburse COVID-19 losses—a particular problem for smaller and safety-net hospitals without large reserves.

This situation raises ethical concerns. For example, it is ethically relevant that COVID-19 resurgence and hospitalizations are linked to states' decisions to reopen quickly to ease economic burdens on businesses and workers. One result has been to shift some of the pandemic's economic burden to the healthcare sector. From a fairness perspective, there should be limits on the losses hospitals are forced to shoulder to maintain COVID-19 preparedness and services. Even if hospitals have reserves, spending them threatens funding for other essential activities, such as capital investment.

The current situation is also fraught with perverse incentives that could jeopardize safe care. With elective care remaining at risk of being reduced,<sup>6</sup> pressure intensifies to deliver as many services as possible as quickly as possible, which may not align with patients' best interests. Across hospitals that need to maximize volume to survive, a push to keep elective services open may emerge, even as COVID-19 prevalence may favor a shutdown. Hospitals with a heavy COVID-19 caseload may have greater difficulty reopening than competitors with lower caseloads, potentially impacting quality if patients seek elective care at lower-volume centers or in ways that disrupt continuity of care.

Ethical dilemmas are also raised by the delicate balancing of interests that hospitals have been engaging in among patient groups. How should they balance the needs of COVID-19 patients against potential harms to others who must delay care?

It is wrong to ask hospitals to make such choices when policy solutions are available. With the resurgence of COVID-19 must come a fresh, sustained program of federal financial relief for hospitals. While direct government support is the swiftest path, consideration should be given to the role of private insurers, which have benefited economically from the widespread deferment and forgoing of elective care. Voluntary or mandatory investments by insurers in helping hospitals survive the pandemic and weather the new normal are consonant with insurers' commitment to providing their members access to high-quality healthcare.

The 200-page National Strategy document released by the Biden administration on January 21, 2021, promises some important assistance to hospitals.<sup>7</sup> It includes plans to accelerate the production of PPE and other essential supplies using the Defense Production Act and other federal authorities, to rationalize nationwide distribution of these supplies and take steps to prevent price gouging, and to deploy federal personnel and assets to help surge critical-care personnel.

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These steps, if fully funded and implemented, would bring welcome respite from some of the most vexing problems hospitals have encountered during COVID-19 surges. Yet, plans for direct financial relief for hospitals are strikingly absent from the National Strategy. Nor does the recently passed \$1.9 trillion federal stimulus package provide dedicated funds for hospitals, though some funds earmarked for vaccine delivery may land at hospitals. These are consequential omissions in otherwise comprehensive, thoughtful pandemic response plans.

Future legislation should include an immediate revenue infusion to reimburse hospitals' COVID-19 preparations and lost volume and a firm commitment of ongoing financial support for preparedness through the end of the pandemic at a level sufficient to offset COVID-19-related losses. Experience with the CARES Act also suggests specific lessons for statutory design: support for hospitals should be allocated based on actual COVID-19-related burden for preparation and care, unlike CARES Act grants that were allocated based on hospitals' past revenue and Medicare billing. This resulted in some large payments to relatively well-off hospitals and scant support for others (eg, rural or safety-net hospitals) with substantial COVID-19-related losses, a misstep that should not be repeated.

Hospitals are an integral part of the nation's public health system. In the context of a pandemic, they should not be forced to serve as a backstop for shortcomings in other parts of

the system without assistance. They, and their mission during the pandemic, are too important to fail.

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Disclosures: Dr. Kachalia serves in a systemwide role as senior vice president for patient safety and quality at Johns Hopkins Medicine.

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