April 3, 2020

The Honorable Alex Azar  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Secretary Azar,

On behalf of children’s hospitals across the country, we thank you and the Health and Human Services (HHS) staff again for your continued work to address the COVID-19 pandemic and support the health care system through this crisis. In follow up to our letter earlier this week, we are providing additional impact data and recommending methodology appropriate for pediatrics in allocating the Public Health and Social Services emergency funding in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

As you know, in mid-March the U.S. Surgeon General and numbers of state governors requested the hospital industry cancel all elective or deferrable care to create surge capacity to accommodate growing coronavirus volumes. Children’s hospitals fully participated in these state and national efforts to support the COVID-19 crisis and as a result are experiencing very real and ongoing financial burdens.

An analysis of the impact on COVID-19 on children’s hospitals quantifies revenue losses in the billions and preparation and protection-associated operating costs in the hundreds of millions quarter over quarter. There is no scenario where children’s hospitals can absorb the impact and continue operations without relief. Like other hospitals participating the national COVID-19 surge response, inclusion in CARES is essential.

To assess initial impact, 20 of the nation’s leading children’s hospitals reported their initial experience and projected results over the coming few months. These hospitals are the leading providers of the most complex pediatric cancer, cardiovascular, trauma and lifelong chronic care in their regions and across the nation. All are academic teaching and research hospitals, governed as charitable, community benefit organizations. Their experience illustrates the real challenges the broader children’s hospital community faces.

Unlike thousands of hospitals participating in the Medicare program for adults, children’s hospitals cannot benefit from federal relief based on Medicare definitions or adult COVID-19 patient care volumes. For this pediatric sector of our health care industry, Medicaid is the dominant payor, representing over half of all child-patient volumes.

Initial Impact of Response to COVID-19

As a cohort, the sample size of children’s hospitals represents ~$18B of patient service revenue with an aggregate operating margin in the single digits. The impact of deferring pediatric care has been immediate and substantial:

- Patient care revenues immediately declined in the range of 20–40% with some institutions reporting even higher losses of volume. Total revenue losses are substantial despite collaboration at local levels to consolidate care for children and bring greater numbers of young adults to the children’s hospitals.
• Despite deferring cases, pediatric intensive care beds have remained close to capacity (80–85%+ utilization) caring for acutely ill and complex non-elective children without COVID-19. This has severely limited the creation of new critical care capacity to take on surge volumes.

As revenues have declined, operating expenses have increased 5–10% with a quarterly negative impact of $200+ million across the 20-hospital cohort:

• Anxious families arrive to children’s hospital’s emergency departments with symptomatic children requiring expansions of screening and testing to rule out COVID-19 from flu, which is widely prevalent.

• Hospital staff, patients and the families who must accompany them in their care comply with what are now mandatory protective cautions, increasing PPE utilization and costs comparable to adult hospitals. There are also increased costs necessary to establish isolation zones and create higher levels of sterilization and infection control across entire institutions.

The net impact on these hospitals over the coming quarter is expected to reach upwards of $1 billion negative cash flow, representing a monthly impact of $10–30 million per hospital, with larger children’s hospitals facing much higher levels. We support funding relief as soon as possible to address these serious financial challenges.

**Methodology for funding allocation**

Recognizing the financial burdens on children’s hospitals, we ask you include the following as you develop the allocation methodology:

• Revenue losses incurred by participating in national COVID-19 surge response resulting from deferral of cases to increase capacity and the need to reduce avoidable use of PPE.

• Cost increases to protect fragile child patients, hospital and ambulatory staff and families, particularly in the areas of PPE, screening and testing, and facility and staffing changes to best protect against virus spread.

• Volumes and cost of care for highly complex children who need additional support to prevent spread of the virus, as demonstrated by case mix index (CMI), patient transfers received, and number of Intensive Care Unit (ICU) beds.

• Medicaid as dominant public payor, recognizing that children’s hospital patients are not enrolled in Medicare.

• Any allocation methodology heavily weighted towards Medicare-based metrics or direct COVID-19 care will not work for children’s hospitals.

The COVID-19 response has produced substantial negative financial impacts on children’s hospitals. The allocation of the recently enacted CARES hospital relief must recognize children’s hospitals’ support for the national capacity surge and resulting financial challenges equitably with hospitals directly caring for COVID-19 patients.

Thank you for your consideration of these recommendations and we stand ready to partner with you to best support the nation’s pediatric health care system through this crisis.

Best regards,

Mark Wietecha
President and CEO
Children’s Hospital Association