Week in Review: 05 – 09 April 2021

BRIEF19

A daily review of covid-19 research and policy.

POLICY BRIEFING

Medicare and Medicaid starts to collect payments from its pandemic hospital lifeline program.

Around the United States during the pandemic, many healthcare systems faced significant financial hardships that nearly brought them to the breaking point. In an effort to support hospitals, the Centers for Medicare and Medicaid (CMS) (an agency within the US Department of Health and Human Services) has been behind the expansion of the Medicare Advanced and Accelerated Payment Program under the CARES Act. This has allowed healthcare entities to request reimbursement for expected future income based on prior years' Medicare data, with set timelines for repayment.

Under the initial expansion, those repayments would have been due one hundred and twenty days after submission, with any failure to comply resulting in a total reduction of future Medicare funding until the balance was paid back in full. With the pandemic still raging, though, organizations like the American Medical Association petitioned CMS to extend the deadline. This goal was achieved with the Continuing Appropriations Act of 2020, which gave applicants one year from dispersal of funds to make payments back to CMS.

We have now reached that one-year mark. CMS has published guidance on recoupment of the Coronavirus Advanced and Accelerated Payments (COOPs) paid out over the pandemic. Under the terms, borrowers will essentially have seventeen months to make good on owed payments. After that time, remaining balances will begin accruing four percent interest, with the rate reassessed every thirty days. So far, there have been no public pushes to further extend the deadline. The healthcare industry is in a stronger position than it was last fall, and so it remains unclear if any effort to kick the can down the road any further would be fruitful. *Various. 9 April 2021.* *—Brief19 Policy Team*

Vaccine mandates for healthcare workers.

Last week Houston Methodist Hospital made headlines by becoming the first major hospital system to require its twenty six thousand employees to receive their first SARS-CoV-2 vaccination or obtain a waiver by mid-April. The announcement cited the need for a major healthcare center to lead by example, especially since some healthcare entities are waiting until the US Food and Drug Administration (FDA) grants its full approval to the vaccines (rather than Emergency Use Authorization, currently granted to the Moderna, Pfizer/BioNtech, and Johnson & Johnson options) before issuing such a mandate.

Eclipsing this in scope, and announced in the same week, Italy issued a national mandate on April 1st, declaring that all healthcare workers must promptly begin the vaccination process, becoming the first European nation to do so. Unlike the surprisingly high percentage of healthcare workers in the United States who have not pursued a vaccine (though fortunately this number has been dropping over time), Italian authorities estimate that just one in ten thousand of their healthcare workers has refused coronavirus vaccination so far.

Such requirements raise interesting ethical questions. The National Bioethics Committee in Italy generally supports voluntary measures but also notes that accepting mandates under special circumstances may be necessary. In this case, it called vaccination "an ethical obligation for health professionals."

In addition, the constitutionality of the vaccine mandate in Italy been called into question and experts anticipate that there will be legal challenges. While there is precedent in the United States for vaccine mandates, court decisions abroad could provide a preview of the road ahead in the United States, once the FDA issues full approvals for the vaccines. *Various. 8 April 2021.* *—Brief19 Policy Team*

Federal government investing in evidence.

One of the biggest limitations in accurately understanding and tracking the pandemic has been the availability of testing supplies and equipment. From delays in getting results and internal power struggles for control of the data, there have been many hurdles to overcome.

The federal government has recently made great strides in increasing the availability of testing, with the US Food and Drug Administration (FDA) approving home kits without a prescription for serial evaluation, and partnering with companies whose products automatically report their results, all in the name of increased surveillance.

On the heels of this, the US Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) have launched a new pilot program to determine the efficacy of such frequent monitoring. Rapid home antigen tests will be made available to residents in Pitt County, NC and Hamilton County, TN, in quantities such that 160,000 people will be able to test themselves three times a week for a month.

Part of the study will determine if self-awareness of infectivity will change daily behavior and decrease rates of transmission. While participation is voluntary, the program's designers hope that the ease of availability, speed of results, and online support will produce robust results. Up until now, many have theorized that at-home testing would give people the information they need to "do the right thing," by staying home and isolating themselves from others while contagious. This new program will test whether such behavior modifications really happen, and how effective they are. At home testing may help decrease the spread of SARS-CoV-2 to a small degree. Alternatively, it could help decrease spread by a large amount. If the latter turns out to be the case, it will validate the opinions of many experts who have been saying for a year now that at-home and other point-of-care rapid antigen testing regimens could save hundreds of thousands of lives. *Various*. *5 April 2021*. *—Brief19 Policy Team*

Federal bailout money disproportionately benefited wealthy hospital systems.

At the beginning of the pandemic, it seemed that hospitals might be immune to the economic downturn felt across the world. Many observers assumed that patient volumes in emergency rooms and inpatient hospital wards would be higher than ever, leading to sustained—if not increased—revenues. The harsh reality soon set in, however, as cancelled clinic appointments, surgeries, and elective procedures caused hospital systems to hemorrhage money. Because of this financial hardship experienced by the very institutions who were tasked with treating sick covid-19 patients, many received federal bailout money. Naturally (to no one's surprise), some hospitals benefited more than others.

Like many businesses large and small, hospitals around the country faced difficult decisions about whether to lay off or furlough employees as revenue fell. Then the federal government stepped in and sent relief funds to many of those hospitals. The upshot is that some—many of the nation's wealthiest health systems—are now flush with cash, while others remain near insolvency.

Outlined in reporting by *Kaiser Health News*, the degree of discrepancy was a result of the uneven distribution of funding as determined by the US Department of Health and Human Services (HHS) during the earlier days of the pandemic. Instead of assessing which hospitals were the neediest, relief was provided based on hospitals' typical yearly revenue. This favored those systems who care for a greater proportion of privately insured patients. In other words, the hospitals that are always short on cash because they take care of uninsured and underinsured patients, suffered even more during the covid-19 pandemic. While some hospital systems are returning their surplus cash to the Federal Treasury, others are retaining it with the expectation that further costs will be incurred as the pandemic drags on.

The current administration, HHS, and Congress will continue to review these programs. But it comes as no surprise that the wealthy hospital systems have emerged from the darkest days of the pandemic, while many public city and rural hospitals—the very institutions that treat the populations most affected by covid-19—will continue to struggle. *7 April 2021*. *—Fred Milgrim, MD*

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Brief19 is a daily executive summary of covid-19-related medical research, news, and public policy. It was founded and created by frontline emergency medicine physicians with expertise in medical research critique, health policy, and public policy.