
HMA

HEALTH MANAGEMENT ASSOCIATES

*Analysis of the Financial Impact of COVID-19
on Pennsylvania Hospitals*

PREPARED FOR
HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

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Executive Summary

The Hospital and Healthsystem Association of Pennsylvania (HAP) engaged Health Management Associates (HMA) to complete a review of the financial impact of the novel coronavirus (COVID-19) on Pennsylvania hospitals. HMA conducted interviews with hospital leaders representing several health systems in Pennsylvania (see Appendix B for the list of hospital systems). From the data shared and applying extrapolation methods, we developed statewide estimates of the disruption seen by hospitals in March and projections of the financial impact over the duration of the year.

Hospitals began to experience significant operational and financial impacts starting in mid-March, coinciding with federal guidance, operational necessity and statewide orders to cancel or reschedule all services determined to be non-emergent or unnecessary to preserve organ function or avoid further harm from underlying conditions or diseases. As such, the March results represent less than half a month of the full impact. Even so, we estimate Pennsylvania hospital operating margins declined by \$914 million in March compared to expected amounts. This decrease is largely attributable to a loss of revenue related to cancelled and deferred services, which often have higher overall margins than those services remaining. Operating expenses did not change materially as cost savings from deferred services were replaced—and at times eclipsed—by the more resource intensive COVID-19 service delivery and preparation activities.

Although there is much uncertainty regarding the length and scale of the remaining pandemic period, hospitals forecast significant losses across the April to June quarter. These projections vary based on assumptions such as projected volumes of COVID-19 patients, timing of reinstating elective procedures, and shifts in payer mix due to the economic downturn. We estimate the operating shortfall statewide to range from \$4.40 billion to \$4.86 billion.

Because of uncertainties, most systems we surveyed did not attempt to forecast the second half of the year, but it is generally believed that negative impacts will persist. If negative margins are 10% of revenue (which some believe is optimistic) this would result in an additional \$4.7 billion margin shortfall for July-December 2020.

The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act¹ allocated \$100 billion in grant funding to providers. The first \$30 billion was distributed in April 2020. We estimate that Pennsylvania hospitals and health systems would receive to \$3.13 billion if all \$100 billion goes to health care providers and is distributed in the same proportion as the initial \$30 billion payment— about 30% of estimated 2020 margin shortfall.

Report Highlights	Statewide Estimates
Operating margin shortfall:	
March 2020	(\$0.9 billion)
April – June 2020	(\$4.6 billion)
July – December 2020	(\$4.7 billion)
Total margin shortfall	(\$10.2 billion)
CARES Act payments	\$3.1 billion

¹ Pub. L. 116-136

As the COVID-19 disruption continues, hospital financial concerns about liquidity will grow. Medicare recently accelerated hundreds of millions of dollars in payments to hospitals across the state, but the repayment of these funds is scheduled to begin in 120 days—coinciding with a time of expected cash flow concerns for hospitals. Without a better understanding of when and how hospitals will be able to again ramp up services, it is unclear whether many hospitals will be able to ride out the financial disruption caused by this crisis.

Introduction

As of April 17, 2020, medical professionals across the United States have diagnosed more than 701,131 cases and attributed 36,997 deaths to the novel coronavirus (COVID-19).² With the most severe COVID-19 patients needing resource-intensive hospitalization in critical care units, along with invasive ventilation, hospitals across the country have spent the last month preparing for and/or weathering an unprecedented surge. This, coupled with a severe economic downturn, has resulted in financial challenges for hospitals. Although the third federal COVID-19 stimulus package, the Coronavirus Aid, Relief, and Economic Security (CARES) Act³, included a \$100 billion provider relief fund, a JP Morgan analysis estimated this fund may cover only two months of lost hospital revenue.⁴

Models predicting the volume, peaks and duration of COVID-19 infections and the variation by region are being revised continuously but the fact is, no one is certain what will occur. However, due to the impact of factors such as federal guidelines and state limitations on elective procedures and public anxiety toward seeking non-emergent care, hospitals will likely shoulder a significant economic burden for months to come.

To quantify the projected total financial strain hospitals will endure through the duration of this crisis, and to evaluate the adequacy of current support available at the state and federal levels, the Hospital and Healthsystem Association of Pennsylvania (HAP) engaged Health Management Associates (HMA) to conduct interviews with hospital financial leaders across the commonwealth. This report contains a summary of the interview responses and analysis of the data supplied.

Approach

Between Wednesday April 15, 2020, and Thursday April 16, 2020, HMA conducted interviews with hospital leaders representing several health systems in Pennsylvania (see Appendix B for the list of hospital systems). These interviews captured information related to the following:

- Operational changes and preparation to ready facilities and staff for the treatment of large numbers of COVID-19 patients

COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU), accessed April 17, 2020.

<https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>

³ Pub. L. 116-136

⁴ JP Morgan. A Breakdown of the CARES Act. Accessed April 17, 2020.

<https://www.jpmorgan.com/country/US/en/research/cares-act>

- Preliminary results of March operations, focusing on the impact of the crisis on the operating margins and revenue compared to budgeted estimates or the previous year
- Forecasted results including assumptions related to the projected length of the pandemic impact
- Estimated governmental support at the state and federal levels, including short term loans, changes to public payer reimbursements, disaster-related cost coverage, and grant funding
- Cashflow issues and potential solutions now and through the end of the crisis

This report contains summarized information and extrapolations based on these interviews. Identifiable information at the hospital or health system level will remain confidential.

COVID-19 Precautions and Industry Response

Beginning in early March clinical and governmental cautions began to emerge regarding non-emergent medical care in hospitals and other medical sites given exposure risks to COVID 19, and the need to ramp up to handle the crisis. Following on, governmental guidance and then state orders severely restricted such non-emergent visits and treatment. This effectively required that hospitals cancel all elective admissions, surgeries, and procedures, to make available hospital capacity to treat COVID-19 patients. The term “elective” is used broadly to include to all services and procedures beyond ones that would be emergent or urgent to save a life, preserve organ function, or avoid further harms from an underlying condition or disease.⁵ This order, along with additional surge preparation activities and safety precautions, typically resulted in the following operational changes across health systems:

- Consolidation and/or temporary closures of ambulatory care centers
- Repurposing medical/surgical hospital space as critical care space to allow for increased Intensive Care Unit (ICU) capacity for COVID-19 patients
- Redirecting staff to areas most in need of resources and providing all necessary training to ensure staff are prepared and safe
- Restructuring hospital space to allow for increased social distancing as well as safe separation of COVID-19 diagnosed or suspected cases from other hospital patients
- Instituting health screening, including temperature checks, at hospital entrances for employees and visitors
- Setting up and staffing COVID-19 testing tents outside of emergency departments (EDs) and within the community
- Shifting as many services as possible to telehealth
- Shifting staff to teleworking where possible and enhancing information technology (IT) infrastructure where necessary

⁵ Pennsylvania Department of Health. Guidance on Hospitals’ Responses to COVID-19. <https://www.health.pa.gov/topics/Documents/Diseases%20and%20Conditions/Guidance%20on%20Hospital%20Responses%20to%20COVID-19.pdf>

In addition to operational changes, throughout this crisis hospitals have also spent significant amounts of time and resources preparing for the surge by:

- Procuring Personal Protective Equipment (PPE) and other equipment such as ventilators
- Revising and/or creating new policies in relation to hospital activities such as testing, cleaning protocols, staffing ratios, staffing benefits, and visitation limits

Estimating the Impact

Given the radical changes as to how hospitals and health systems are operating in the face of the pandemic, organizations have recently seen associated fluctuations in financial performance — especially related to hospital revenues. Based on the information captured in the interviews, in the next section we estimate the overall impact of the crisis on hospitals in Pennsylvania. The information available to make these estimates is limited given that the disruption largely occurred over the last two weeks of March, and hospitals prepare financial statements on a monthly basis. As such, through the interviews we have collected roughly two weeks of reliable actual financial data, as well as two additional weeks of actual patient activity statistics for April.

In addition to the actual data collected, we have captured forecasted results where available. Some systems have forecasts only month-to-month, some for an additional few months, and some to the end of the calendar year. Organizations described to us the various assumptions necessary to create forecasts in these uncertain times, including assumptions related to the following:

- Duration of the disruption
- Estimated time period for reopening the economy (i.e., loosening forced business closures, service restrictions, and stay-at-home orders)
- Rate at which patient volumes will return once restrictions begin to loosen
- Ability of hospitals to manage operating expenses
- Availability of federal and state emergency and other fiscal relief funding

Analysis of Hospital Financials

In 2019, hospitals in Pennsylvania had \$47.7 billion of revenue⁶, and the hospital systems represented in our interviews account for an estimated 40% of hospital and health system patient revenue across the commonwealth. Using this relationship, we have extrapolated our combined survey results to estimate statewide numbers.

⁶ Pennsylvania's Health Care Cost Containment Council (PHC4). Financial Analysis 2019. http://www.phc4.org/reports/fin/19/docs/fin2019report_volumeone.pdf

March 2020 results

For the month of March, consolidated operating results for the systems in the survey were **\$371 million** below expectations.⁷ Projecting these results to all Pennsylvania hospitals and health systems, the statewide variance is an estimated **\$914 million** for March.

After canceling or delaying all elective procedures and services mid-month, March hospital operating margins dropped by an estimated \$914 million compared to expectations.

Nearly all of the negative variance was the result of precipitous declines in patient volume. Inpatient discharges dropped by 10% to 20% and outpatient volume fell more significantly. As explained below these changes represent a decrease in activity for only a portion of March. The full month effect would be significantly higher. The decreases are primarily due to the abrupt cancellations and deferrals of elective and scheduled

procedures, treatments and diagnostic tests. Hospitals began voluntarily reducing volume in mid-March and Governor Wolf's order made it a requirement a few days later. The volume declines are also attributed to the shutdown of many economic and social activities as well as patients deciding to forgo medical care.

Patient revenue decreased by even larger percentages than patient volumes. Surgeries and complex tests and treatments that had to be canceled or delayed generate more revenue per encounter than the emergent and other medical services that are not subject to the restrictions. In addition, initial results suggest that revenue losses from elective and complex surgeries are more heavily concentrated in the loss of commercial business and Medicare procedures having higher DRG reimbursement.

Overall, operating expenses in March did not vary significantly from expected levels. Reducing surgical procedures generates savings in medical devices and supplies, and closing ambulatory sites saves some facility costs. However, salaries and benefits comprise over half of hospital expenses and many of the non-workforce related expenses are fixed (they do not increase or decrease with volume). Few hospitals had workforce reductions in March, and none of the interviewed systems reported significant labor cost savings.

All health systems incurred significant costs from pandemic preparedness activities such as procuring supplies and equipment, implementing testing, and other activities discussed earlier. Due to increased demand, some supply costs have skyrocketed, and some additional costs were incurred to replace staff that were self-quarantined due to known exposure. In some instances, these extraordinary costs exceeded the savings from reduced patient activity.

As mentioned above, the March 2020 losses occurred over only part of the month. Cancellation and deferral of elective procedures began mid-month and the dramatic changes in patient volume levels occurred over the last half of the month. In fact, many organizations commented that operations were

⁷ Most systems used a comparison of actual results to budget to present the variance from expected results, while some used average operating results for the first eight months of the fiscal year and others used March 2019 for the comparison.

exceeding expectations for the first half of the month, potentially masking the adverse impact in the second half. The volume decreases did not all occur on mid-month but rather accelerated over the balance of the month. For example, surgical patients that were in the hospital on March 15 continued to receive care until they could be safely discharged.

Systems were asked to estimate, if the changes had been in place for the full month of March, what would have been the effect on revenue and operating losses? All organizations believe that the decline in patient revenue and the operating losses would have been at least 100% more, and the estimates range as high as 200% more.

We estimate that if the patient activity restrictions and reductions had been in place for the full month, the negative variance for March would have been **\$825 million** for the systems in the survey and **\$2.03 billion** statewide. This exercise is important, because it puts into perspective the forecasted results for the April-June quarter discussed in the next section. The volume and revenue losses during the latter part of March are continuing unabated through April and will probably continue well beyond April as discussed below.

If patient activity restrictions had been in place for the full month, March operating margins would have been down an estimated \$2.03 billion statewide.

April-June results

Most of the organizations have forecasted operating margins through June and the variance from expected performance. In two instances, a forecast has not been completed but information about expectations for April and beyond enabled us to estimate the margin variance. Two of the organizations provided ranges for April-June.

For the quarter ending June 30, 2020, forecasted operating margins for the systems in the survey range from **\$1.79 billion to \$1.97 billion** below expectations. Projecting these results to all Pennsylvania hospitals and health systems, the statewide estimated operating shortfall ranges from **\$4.40 billion to \$4.86 billion**. These estimates are before considering any funding from federal relief legislation.

Estimates for the April to June 2020 quarter range from operating shortfalls of \$4.40 billion to \$4.86 billion statewide.

The forecasting methods and assumptions vary considerably from system to system depending upon several factors.

Patient volume is the most important variable, and there are two major uncertainties. First, the number of COVID-19 cases and the extent of COVID-19 hospitalizations are unknowns, and estimates vary widely about the effect on hospital inpatient units and emergency rooms. Second, and

more significant, is the timing of elective and scheduled procedures, tests and treatments: when will current restrictions or operational obstacles loosen and at what point will care that is currently being deferred become urgent?

There is consensus among the systems that the enormous decreases in volume experienced in the latter part of March have continued into April and will continue through the end of April. Most of the organizations believe there could be a modest improvement in May, as the disruption begins to loosen and there will be continued improvement through June, although there are no consensus assumptions around pace of these improvements.

Another important variable in these forecasts is the potential savings from workforce reductions. Along with the decline in patient volume, there has been a net reduction of work in providing and supporting patient care. The response to the reduction varies considerably. Some organizations have repurposed all staff to perform other work such as implementing the new safety measures, delivering testing, cleaning, and replacing volunteers who can no longer come to the hospital. Some organizations have furloughed staff or may implement furloughs, while others are waiting to see what happens with the COVID-19 caseload and restrictions on elective procedures. For those which have furloughed staff, savings have yet to be significant because staff are first accessing paid time off benefits, and many organizations will directly bear the cost of unemployment benefits because they self-insure.

All of the healthcare systems are monitoring the situation closely; hospitals cannot be caught short-handed if the COVID-19 surge accelerates and no one wants to be understaffed when normal activity resumes. Some hospitals noted challenges with retaining and recruiting staff outside of the pandemic and had concerns with having the ability to rebuild their workforce if it were temporarily reduced during the crisis period. Others cited the potential extreme conditions staff could be working under if/when a surge occurs as reason to provide more flexible benefits and leave-of-absence policies in the interim.

Finally, changes in insurance coverage will affect financial performance. As unemployment rates are skyrocketing across the country, millions may lose employer-based health care coverage and some with individual coverage may not be able to continue to pay the premiums. There will be a shift from private insurance to Medicaid and uninsured. HMA recently produced a model⁸ that estimates, nationwide:

- Medicaid enrollment could increase by 11 million to 23 million
- Uninsured could increase by 2 million to 11 million
- Privately insured could decrease by 13 million to 34 million

To the extent that these shifts occur, hospital systems will experience further erosion of their net revenue. Medicaid payment rates are significantly lower than private insurance rates, and most care to the uninsured will be uncompensated. Three of the organizations we surveyed accounted for the expected shift in payer mix in their forecasts, while the others did not. As a result, the negative variance for the quarter could be greater.

⁸ Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. April 3, 2020. <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>

After June 2020

Predicting the financial impact of the pandemic after June 2020 is even more uncertain than forecasting results through June. Just as there will be a gradual easing of stay-at-home and social distancing requirements, there will be a gradual recovery of surgeries, diagnostic testing, treatments, and clinic visits and emergency room activity. Some believe the rate of recovery may be faster than other sectors of the economy because of pent-up demand for healthcare services, while others have more conservative views.

Only two of the systems we interviewed have forecasts beyond June 30 and these two forecasts vary significantly. The more optimistic of the two forecasts predicts that the negative variance from July-December will be 10% to 15% of revenue. If we apply a 10% factor to statewide hospital and health system revenues for half of the year, additional operating margin impacts from July-December 2020 would be approximately **\$4.7 billion**. This amount is not a forecast per se, but it is presented to provide an idea of the potential magnitude of the disruption to hospital operations for the last half of the year. Notwithstanding all of the previous comments, there is significant concern among some healthcare experts that a respite of COVID-19 activity during the summer months could be followed by an aggressive return and corresponding increase in COVID-19 cases in the latter part of the calendar year and early 2021.

Federal Relief Funding

Recent federal legislation, referred to as the CARES Act, provides direct financial relief to health care providers.

- \$100 billion is authorized for direct payments to healthcare providers. The first \$30 billion was distributed last week proportionate to providers' share of Medicare fee-for-service reimbursements in 2019. The timing and distribution of the remaining \$70 billion is uncertain; the administration has stated that it will target hospitals and providers in hotspot COVID-19 areas, rural providers, and providers with lower shares of Medicare reimbursement or who predominantly serve the Medicaid population.
- Two Medicare payment changes were announced, increasing the payment rates by 20% for COVID-19 inpatients, and eliminating the 2% sequestration for the last eight months of the year.

In addition, the Federal Emergency Management Agency (FEMA) will reimburse 75% of the costs of "eligible emergency protective measures taken to respond to the COVID-19 emergency at the direction or guidance of public health officials".⁹ A FEMA fact page provides a listing of costs that may be reimbursable, if not otherwise funded from other sources.

⁹ <https://www.fema.gov/news-release/2020/03/19/coronavirus-covid-19-pandemic-eligible-emergency-protective-measures>

We estimate that CARES Act payments to Pennsylvania hospitals and health systems may total **\$3.13 billion** assuming all \$100 billion will be distributed to health care providers. This estimate assumes that:

- Hospitals and health systems received approximately \$0.9 billion of the \$1.2 billion paid to Pennsylvania providers from the initial \$30 billion distribution
- The remaining \$70 billion will be distributed to providers proportionately to the first \$30 billion
- Medicare sequestration relief provides an estimated \$25 million
- The 20% increase in payment rates for COVID-19 inpatients is offset by a corresponding increase in the cost of care.

Federal CARES Act funding is estimated to provide an expected total of \$3.13 billion in financial relief to Pennsylvania hospitals.

No estimate of FEMA reimbursement is available, but the total is likely to be in the hundreds of millions statewide. FEMA reimbursement is meant as a payer of last resort and many health systems interviewed noted the complexity in determining what costs are eligible for reimbursement given the other federal funding streams. Several noted the need to engage a third party to assist in navigating the system and compiling and submitting claims.

Cash

Financial losses of the magnitude discussed above have several negative consequences to hospitals and health systems. The most immediate and pressing concern is whether providers have sufficient cash to remain in business.

Summing the estimates described above for losses from March-December 2020, less federal relief funding, hospitals and health systems in the state could be facing a shortfall in 2020 exceeding \$7 billion, with a corresponding decrease in the cash needed to sustain their operations. We estimate that average daily operating expenses across the state are \$150 to \$160 million. A \$7 billion margin reduction would use about 46 days of cash. Actual results will vary from hospital to hospital, and cash needs will be greater for some.

Many hospitals do not have enough readily available cash and investments and could not remain open without additional financing.

The Centers for Medicare and Medicaid Services (CMS) used its emergency authority to offer accelerated Medicare payments to providers. All of the system that we surveyed took advantage of this program and have received or expect to receive Medicare advances. These advances will help ensure that hospitals and health systems have the liquidity they need for the short-term. However, under the conditions of the program, the advances must be repaid after 120 days (generally in August), and consequently the advance provides only temporary relief.

All of the organizations we interviewed are taking additional steps to provide sufficient liquidity. All have secured or are working on securing lines of credit and other short-term financing from private banks, and some are planning to utilize the Hospital Emergency Loan Program, or HELP. In addition, capital

expenditures (buildings, equipment and information technology) are being delayed where possible. Lastly, during the pandemic emergency, essential businesses are allowed to defer employer contributions to social security and hospitals are taking advantage of this temporary savings as well.

Other Concerns

Several related financial concerns were raised during the interviews, including the following:

- Equity market values declined significantly in March, and many investment experts believe there could be further declines as the economic slowdown continues. Many hospitals have significant holdings and pension assets in market-sensitive investments and the recent loss of value further weakens the hospitals' financial position.
- Debt financing concerns. Sustained operating losses and weakened balance sheets could have adverse implications for current and future borrowings. Many hospital borrowings are made under agreements that include financial provisions (often called covenants) imposed by the lenders requiring the borrower to maintain specified levels of net income or cash. Failure to meet debt covenants may result in a default, and the amount borrowed becomes immediately due and payable. This scenario often leads to bankruptcy or closure. In addition, the deteriorating financial position will adversely affect the credit worthiness of many hospitals and make it more difficult and more expensive to obtain future financing.
- The financial data presented in this report does not include the effects on affiliated physicians and physician group practices that are not owned or employed by the health system. These independent physicians are experiencing the same financial strains as hospital-controlled physicians and their ability to weather the current crisis is critical to the hospitals.
- Pennsylvania has several academic medical centers (AMCs), including five that were surveyed for this report. The medical education and research arms of these AMCs typically receive significant funding from patient care operations. The expected margin shortfall will impact the ability of hospitals and physician faculty group practices to support the academic mission at expected levels.

Conclusions

The current pandemic is resulting in a dramatic disruption of patient care and enormous losses for most hospitals. Forecasting the financial impact of the crisis is challenging given that we only have two weeks of relevant financial results, four weeks of relevant patient volume data, and highly volatile predictions about the extent and duration of the disruption.

We obtained information about the bottom-line impact from 12 hospital and health systems for March 2020 and their forecasts for the quarter ending June 30, 2020 and projected those amounts to all Pennsylvania hospitals and health systems. From March through June, hospitals and health systems could incur a shortfall ranging from **\$5.3 billion to \$5.8 billion**.

The current restrictions and operational limitations on non-emergency patient care and requirements for social distancing may begin to loosen in May but the changes will be gradual and a full return to

normalcy will probably not occur until 2021. Most systems we surveyed are unable to forecast beyond June 2020, but under what might be a best-case scenario, an additional loss of \$4.7 billion may occur from July through December 2020.

We also captured information about federal emergency funding intended to reduce provider losses. Over \$3 billion may be available to Pennsylvania hospitals and health systems from the March 2020 CARES Act and additional relief is available from FEMA reimbursement. These sources will mitigate the operating losses.

The net effect – projected and estimated losses in 2020 less available federal relief funding – is likely to exceed **\$7 billion**. To provide context, hospital net patient revenues for fiscal year 2019 were \$47.7 billion.

Appendix A: Cancellation of Quality Care Assessment Payments

In addition to the financial analysis, HAP requested that HMA provide an analysis of the federal permissibility of cancelling or reducing the third and fourth quarter obligations under Pennsylvania's provider assessment program, the Quality Care Assessment (QCA). We believe that if the change in assessment collection applies uniformly to all hospitals, the QCA will continue to meet all federal requirements as described below.

Federal Provider Assessment Regulations

Federal regulations allow states to impose assessments on health care providers and use the funds to draw down federal match for the Medicaid program. To be eligible for federal funds, the state must implement the provider assessment consistent with the following conditions¹⁰:

1. It must be broad based, i.e., all providers or services in a class of services must be assessed.
2. It must be uniform, i.e., all providers in the class of services must pay the same assessment rate.
3. No assessed entities can be guaranteed to directly or indirectly be "held harmless"

Waivers of the Broad-Based and Uniform Requirements

A state can request a waiver of the broad based and/or uniformity requirements to exclude certain types of providers, such as psychiatric hospitals, or assess providers at varied rates, if it passes statistical tests consistent with the requirements outlined in federal regulation.

Pennsylvania currently holds a waiver of the broad-based requirement as the QCA exempts certain hospital types, but all included hospitals pay the same uniform rate. To receive the waiver of the broad-based requirement, the commonwealth had to submit a statistical test showing that the assessment structure does not unfairly burden high Medicaid providers when compared to an assessment that includes all hospitals. Because this test looks at the relative burden by hospital, it is scalable, and the results do not change based on the total amount of assessment collected. Therefore, uniformly reducing the assessment obligation will not jeopardize Pennsylvania's broad-based waiver.

Hold-Harmless Standard

Any payer of a provider assessment must not be guaranteed that it will get its assessment payment back, that it would be "held harmless." There are no waivers to the hold harmless requirement. The hold harmless standard is measured through a direct test and an indirect test of the provision.

A direct hold harmless exists under two conditions. First, if the amount of Medicaid reimbursement the provider receives varies only based on the amount of assessment paid. Reducing the assessment has no impact on the QCA-funded Medicaid reimbursement methodologies. Second, a hold harmless situation exists if the amount of the assessment paid by a provider is positively correlated with a non-Medicaid payment to the provider. Reducing the assessment burden is not equivalent to guaranteeing a non-Medicaid payment to the provider. The indirect hold harmless test measures whether the tax rate is greater than 6 percent of provider revenue—a test that a reduced QCA will continue to pass.

¹⁰ 42 CFR § 433.68

Appendix B: Hospital Systems Interviewed

Between Wednesday April 15, 2020, and Thursday April 16, 2020, HMA conducted interviews with hospital leaders representing the following several health systems in Pennsylvania, including:

- Doylestown Health
- Einstein Healthcare Network
- Excela Health
- Holy Redeemer Health System
- Jefferson Health
- Lehigh Valley Health Network
- Main Line Health
- Penn Medicine: University of Pennsylvania Health System
- Penn State Health
- Tower Health
- WellSpan Health