June 26, 2020

The Honorable Lamar Alexander
Chairman
U.S. Senate Committee on Health, Education, Labor, and Pensions
455 Dirksen Senate Office Building
Washington, D.C. 20510

Re: **Covid-19: Preparing for The Next Pandemic, Request for Comments**

Dear Chairman Alexander:

On behalf of the Trauma Center Association of America (TCAA), and our life-saving trauma center members, I applaud the Committee for focusing on the need to ensure our nation's readiness for the next pandemic. As Senator Bill Frist told the Committee this week, the next pandemic is not a question of if, but a question of when.

Trauma centers and systems play key roles in both the preparedness and response to pandemics. They maintain and support a 24/7 infrastructure for deploying time-sensitive, life-saving interventions and advanced critical care. In addition, regionalized trauma systems ensure coordination among state and local governments, and other health providers to ensure that anticipated surges of critical patients have access to care.

Unfortunately, federal resources for trauma centers and systems have deteriorated to dangerous levels in recent years. For example, funding for the Hospital Preparedness Program, the main federal program responsible for supporting the ability of hospitals to respond to pandemics and other public health emergencies, has declined from $515 million in FY2003, to $276 million FY2020 – just over $3.7 million per year per state.

Ten years ago, Congress restructured several federal grant programs to ensure that trauma centers can fulfill their unique round-the-clock mission with funding to support trauma care and system infrastructure. This funding is intended to support a number of essential functions, including staffing, training, technology, surge capacity, data collection, as well as regional and state coordination.

Despite an increase in public health emergencies – including mass casualty events and the current COVID pandemic – Congress has not appropriated new funding for trauma center and system grants in over ten years.

With this lack of funding in mind, TCAA appreciates the opportunity to provide feedback on the recommendations included in your White Paper.

## TCAA COMMENTS ON "COVID-19: LESSONS LEARNED SO FAR & INITIAL RECOMMENDATIONS"

### RECOMMENDATION 4.2: Ensure that the United States does not lose the gains made in telehealth.

In response to the COVID-19 pandemic, CMS issued 1135 waivers designed to make it easier for patients to receive medical care through telehealth services during the Public Health Emergency. This flexibility was authorized by the Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074). All of these flexibilities are set to expire once HHS declares the Public Health Emergency has ended. As the number of new COVID-19 cases continues to rise, patients understandably remain hesitant about seeking care in public settings. Many may even forgo emergency care.

Many health care providers – including trauma centers – have invested significant time and resources into upgrading and expanding their telehealth capabilities during the pandemic. With these new and improved telehealth capabilities, providers and facilities can meet the healthcare needs of more patients now and in the future. But providers can only take advantage of this advancement if Congress enacts legislation to continue the expansion of this lifesaving and life-improving technology.

*TCAA urges Congress to extend or make permanent many of the telehealth expansion policies enacted in response to the COVID-19 public health emergency.*

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### RECOMMENDATION 4.4: Remove red tape and allow states to use Public Health Emergency Preparedness and Hospital Preparedness Program funds to respond to a public health emergency and report back to HHS on how they were used, rather than having to wait for written approval from Washington.

In the event of a global, national, or regional pandemic, true preparedness to reduce loss of life is critically dependent on the timely availability of resources at the local level. However, federal and state mechanisms for obtaining and distributing public health emergency funds to state and local governments is often incredibly burdensome and time-consuming. As noted in the White Paper, recent history has demonstrated that the requirement of multiple separate applications with separate guidelines for each state to obtain Public Health Emergency Response grants – and the time required for federal approval of the applications – affects states' capacity to respond effectively to pandemics and other public health emergencies.

*TCAA strongly supports the White Paper recommendation to provide essential emergency preparedness funding with as little "red tape" as possible, as well as a requirement that states report to HHS how these critical funds were used.*

## RESPONSES TO QUESTIONS

**Stockpiles, Distribution, and Surges; Question 2:** *How can states and hospitals improve their ability to maintain a reserve of supplies in the future to ensure the Strategic National Stockpile is the backup and not the first source of supplies during emergencies?*

The Assistant Secretary for Preparedness and Response is developing a new Regional Disaster Health Response System (RDHRS), which is designed to leverage and enhance existing programs – including the Hospital Preparedness Program and the National Disaster Medical System – to create a more coherent, comprehensive, and capable health care disaster response system. The RDHRS will include trauma centers, burn centers, pediatric centers, public health labs, outpatient services, and federal facilities like Veterans' Affairs clinics working together to better meet the needs of the public in a disaster or emergency. By financially supporting this endeavor, Congress ensures that emergency responders have the resources to communicate, collaborate, and share resources as needed when confronted with an outbreak like COVID-19.

It is also important that the federal government recognize that trauma centers play a critical role in public health emergencies like the one our nation currently faces. A recent TCAA survey found that 90 percent of respondents to the question "Which facility in your region predominantly provided care to COVID-19 patients?" listed trauma centers in their response. Only ten percent of respondents listed community hospitals or academic medical centers. These survey results highlight the critical need for increased, sustained funding for trauma centers. This funding, when combined with federal funding for programs like the RDHRS, will allow those facilities and providers at the front line of an outbreak to stockpile and distribute essential health care supplies the next time our nation faces a national emergency.

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**Public Health Capabilities; Question 1:** *What specific changes to our public health infrastructure (hospitals, health departments, laboratories, etc.) are needed at the federal, state, and local levels?*

Much of the challenge of maintaining effective trauma centers lies in the financial stability and sustainability of the entire public health system. The two are inextricably linked.

In the current healthcare environment, trauma system finances are stressed. Despite trauma centers' important role in preparing for and responding to public health emergencies, trauma systems as a whole remain woefully underfunded. Finding solutions requires coordination of several efforts, and legislation at the state and national levels will be required.

Trauma centers, like fire and police departments, are available 24 hours a day, 7 days a week. At all times, they must have the full roster of emergency services available, ranging from the entire spectrum of surgical specialists to radiologists, lab technicians to respiratory specialists, and beyond. This level of commitment by trauma centers, coupled with the public expectation for high quality care, requires trauma centers to make considerable investments in readiness.

The concept of readiness poses challenges to traditional billing and reimbursement systems that are based on Diagnosis Related Group (DRG) or Current Procedural Terminology (CPT) coding. Moreover, the cost of readiness is expended regardless of the patient volume or insurance status. Indeed, trauma centers care for all victims of traumatic injury or illness, regardless of their ability to pay. As such, traditional reimbursement regimes do not cover the full spectrum of costs incurred by maintaining 24/7 readiness.

TCAA supports robust, predictable federal funding streams dedicated to the investments required to ensure trauma centers have the facilities, equipment, and personnel they need.

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**Public Health Capabilities; Question 2:** *What changes can be made to Public Health Emergency Preparedness and Hospital Preparedness Program to help states prepare and respond more quickly?*

Trauma centers throughout the country are experiencing significant financial hardship – a hardship that preceded the COVID-19 outbreak. Even before the pandemic, many trauma centers were already operating at full or nearly full capacity. For years, trauma centers have struggled to adapt in the face of significant increases in opioid-related trauma and even the impacts of seasonal influenza. COVID-19 has exacerbated this problem, placing strain on an already strained emergency response infrastructure. A recent TCAA survey found that nearly half of trauma center respondents do not feel that their facility is adequately prepared for a public health emergency.

The pressures outlined above, combined with insufficient federal payment, have made it difficult to sustain training and education for the trauma care workforce. Staff recruitment and retention is particularly difficult, primarily due to the strains associated with 24/7 trauma center readiness. These are some of the significant burdens that trauma care facilities, which are a critical part of our emergency infrastructure, are experiencing that threaten their long-term financial sustainability.

Additional funding is needed to bolster disaster preparedness, stabilize the clinical staffing and ensure that there is sufficient capacity for high-quality trauma care. TCAA, in partnership with our partners in the Senate Health, Education, Labor and Pensions Committee and the House Energy and Commerce Committee, has developed bipartisan legislation aimed at modernizing and funding existing federal trauma programs. This legislation would create grant programs to fund activities necessary to maintain the trauma care infrastructure, such as staffing, training, technology, surge capacity, data collection, regional and state coordination, and other uncompensated costs associated with maintaining a 24-hour state of readiness and response.

We look forward to working with Congress to develop legislation that will provide dedicated, sustainable funding for critical trauma care in every community.