American Hospital Association™
Advancing Health in America

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September 24, 2021

The Honorable Diana Espinosa
Acting Administrator
Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Agency Information Collection Activities: Proposed Collection: Public Comment Request; Information Collection Request Title: COVID–19 Provider Relief Fund Reporting Activities, OMB No. 0906–XXXX New (Vol. 86, No. 140), July 26, 2021.

Dear Acting Administrator Espinosa:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks the Health Resources and Services Administration (HRSA) for the opportunity to comment on the Provider Relief Fund (PRF) reporting portal. America's hospitals and health systems have stepped up in heroic and unprecedented ways to meet the challenges of COVID-19. This has become even clearer during this ongoing and alarming "fourth wave" of COVID-19 cases. **As such, the AHA appreciates the Administration's recent announcement that it intends to distribute $25.5 billion in additional, and critical, relief funding – $17 billion in PRF and $8.5 billion in American Rescue Plan Act (ARPA) funds. We urge the Department of Health and Human Services (HHS) to work with us to expeditiously distribute these funds, as well as additional funds that target the spring, summer and later surges of COVID-19 cases.**

Quickly distributing the $25.5 billion in PRF and ARPA funds, as well as the rest of the PRF funds, is particularly urgent given that there have not yet been any distributions made that were designed to target expenses and lost revenues after June 30, 2020. Yet, as we know, a majority of the country's COVID-19 cases and hospitalizations occurred after this timeframe, most notably in the winter "third wave" and the current "fourth wave." Specifically, for the week ending Sept. 10, 2021, cases continued to

increase in 14 states.[i] Cases increased in more than half of these states by double digits in just one week.[ii] Hospitalization rates also continue to climb, increasing week-over-week in 20 states and the District of Columbia (D.C.).[iii]

Accordingly, hospitals and health systems continue to care for extremely ill COVID-19 patients of all ages. But their resources – human, infrastructure and financial – are being stretched to the brink. COVID-19 has taken a heavy toll on our health care heroes, who have been on the front lines of the pandemic for a full year and a half, with many suffering from trauma and burnout. A number of hospitals have experienced critical staffing issues due to the surge demands of very ill COVID-19 patients, as well as assistance in helping control the pandemic through testing, contact tracing and vaccine deployment. Also with a finite number of clinicians as well as infrastructure, such as beds, many have been forced to make difficult patient care choices. These include once again postponing non-emergent surgeries or transferring certain patients, such as children and expectant mothers, to other hospitals. In some areas of the country, the situation is so dire that crisis standards of care have been activated because there are not sufficient resources to adequately treat patients. Moreover, COVID-19-related expenses are skyrocketing, including for clinicians and other personnel, personal protective equipment, pharmaceuticals and safety equipment, and maintaining testing and additional screening for every hospital patient.

In addition to urgently needing new funding to assist with these challenges, hospitals need more flexibility to retain the funding they have already received. Therefore, we again urge you to revise your guidance to enable recipients to retain access to the funds they have already received through the later of the end of the COVID-19 public health emergency (PHE) or June 30, 2022. Specifically, HHS recently extended the deadline for use of PRF funds, but only for those received after June 30, 2020. The deadline remains June 30, 2021, for any PRF funds received from April 10, 2020 through June 30, 2020. While we appreciate HHS' action, providing additional flexibility is necessary, fair and appropriate. That is because the new guidance disadvantages certain providers without providing a clear policy rationale. Specifically, some providers will need to spend their funds well before others simply because they received a PRF payment earlier in the distribution process. This is particularly troubling since such a large amount of the PRF funds – well over half – were distributed on or before June 30, 2020. And many of the funds provided during that period went to hospitals in high-impact areas, those serving vulnerable populations – particularly individuals of color suffering from health care disparities and inequities – as well as those in rural areas. Moreover, hospitals have worked very hard as partners with HHS and the government in providing vaccinations, particularly in vulnerable communities. **Consequently, we strongly believe that hospitals and health systems should be able to continue to use PRF money "to prevent, prepare for, and respond to coronavirus," as intended under the law, regardless of when they happened to receive a PRF payment.**

HRSA recently made this June 30, 2021, deadline even more problematic by announcing that in order for the costs of a capital project to be expensed, it must have been fully completed by the use of funds deadline. This policy change is extremely challenging. First, hospitals have not been in good positions to initiate, execute *and complete* large capital projects while, of course, treating an overwhelming number of COVID-19 cases, sourcing personal protective equipment, pharmaceuticals and safety equipment, ensuring an adequate and healthy workforce, and helping vaccinate their staff and communities. This is particularly true for vulnerable hospitals and those treating patient populations that have been historically marginalized. Such facilities simply do not have an abundance of extra space to "swing" a patient care unit to when its original location closes for renovations. Large capital projects require a very tight coordination of logistics that is difficult to complete at any time, but particularly during a pandemic. In addition, the agency made this change on Aug. 30, 2021 – two months after the reporting portal opened and just one month before the reporting deadline. Yet, it is a complete reversal of the prior policy, which only stated that a cost must have been "incurred" (or in some cases, "obligated, as described below) in order to qualify as an eligible expense. **We strongly urge HRSA to reverse this change. Further, we ask that it avoid making such wide-ranging modifications, which are announced late in the process (after many providers have already submitted their reporting), refute prior guidance, and disadvantage the most vulnerable hospitals, in the future.**

HRSA also recently announced that it is granting a "final 60-day grace period" to the Sept. 30 deadline for the first PRF reporting period. Specifically, while the deadlines to use funds and the reporting time period will not change, HHS states that it will not initiate collection activities or similar enforcement actions for noncompliant providers during the grace period. **We appreciate this flexibility. That said, we also urge HRSA to establish an *ongoing* exception process under which hospitals and health systems can request reporting deadline extensions due to extreme and uncontrollable circumstances (EUCs).** Such an exceptions process has been implemented in many different areas by, for example, the Centers for Medicare & Medicaid Services, and has served providers, patients and the agency well. Specifically, we recommend that HRSA allow a provider to request an extension of the otherwise-applicable PRF reporting portal deadline if they encounter an EUC, such as a hurricane, or a public health emergency. For example, many hospitals and health systems in Louisiana are currently under a disaster declaration due to Hurricane Ida. Several were forced to evacuate patients after storm damage, with many running on generator power. Internet service has not been available in certain areas, and key staff have been redeployed to focus on maintenance and recovery of critical patient care capabilities. Thus, PRF reporting has not been their key focus.

Such an exceptions process also should apply to hospitals that have encountered documented errors in their PRF payments, or otherwise request a reconsideration of PRF payments, as these will affect their portal reporting. For example, one of our members returned an erroneous PRF payment, but the return of those funds has not

been recorded properly in HRSA's data. As a result, this member did not receive a Phase 3 payment that they are entitled to receive. This administrative error, and other similar issues, must be resolved before portal reporting can be completed accurately. Hospitals and health systems should not be penalized for such circumstances that are well beyond their control.

Finally, we have a number of detailed requests related to the PRF reporting portal. Specifically, we urge HRSA to:

- **Allow "new" hospitals to be eligible for all future funding, including ARPA distributions**. To be eligible for funding, HRSA currently requires that hospital Tax Identification Numbers have been registered in their system prior to 2021. However, a number of our members were purchased out of bankruptcy in 2021. They have thus far been ineligible for new funding and unable to retain funding provided to the previous owner. However, these hospitals are effectively the same hospital as they were before, and they continue to incur COVID-19-related expenses and lost revenue in 2021.

- **Revise reporting guidance to state that, in order to qualify as a COVID-19-related expense, costs must be either incurred or obligated during the period of funds availability.** This "obligated" wording had previously been included in the agency's Frequently Asked Questions document in certain places, but was subsequently removed. Many of our members have been unable to fully execute certain capital projects due to a variety of circumstances outside of their control, such as overwhelming COVID-19 patient volume, or vendor supply chain disruptions, as discussed above. They should not be penalized for these circumstances; rather, they should be able to report these expenses as COVID-19-related so long as they have a contract in place that obligates the funds to be spent.

- **Simplify reporting by allowing targeted distributions to be reported by the entity to which they were reallocated.** Currently, HRSA requires targeted distributions to be reported by the entity that received them, even if they were reallocated to other entities under the same corporate umbrella. If HRSA does not allow these distributions to be reported by the entity to which they were reallocated, PRF recipients would benefit from guidance as to how they are to reclassify and report the expenses and lost revenue related to COVID-19 from the parent entity (or entity that the targeted distribution was reallocated to) to the entity that received the targeted distribution.

The AHA stands ready to work with you and would welcome the opportunity to discuss this critical issue.

Thank you very much for your consideration.

Please feel free to contact me or have a member of your team contact Joanna Hiatt Kim, vice president of payment policy, at jkim@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President

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[i] https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9.
[ii] Ibid.
[iii] Ibid.