American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 22, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Becerra:

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 you for extending the deadline for some recipients of COVID-19 Provider Relief Fund (PRF) payments to use their funds. **However, we urge you to revise your guidance to enable all recipients to retain access to these funds through the later of the end of the COVID-19 public health emergency (PHE) or June 30, 2022, which was the final date adopted in the Department of Health and Human Services' (HHS) most recent guidance.**

HHS recently extended the deadline for use of PRF funds, but only 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 had previously requested an extension and appreciate HHS' action, we believe that 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 acutely felt 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.**

As you know, the purpose of the PRF is to "to prevent, prepare for, and respond to coronavirus" by reimbursing providers for "expenses or lost revenues that are

attributable to coronavirus." Indeed, these funds have been a lifeline for hospitals and health systems and allowed them to continue to put the health and safety of patients and personnel first, and in many cases, ensured they are able to keep their doors open. In the initial distributions HHS largely used proxies that were intended to capture, at a macro level, the extent to which each facility was experiencing increased expenses and lost revenues related to COVID-19. **It is important to recognize that hospitals are continuing to experience exactly these increased expenses and lost revenues. 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 they 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.**

The PHE is very much ongoing. While new COVID-19 cases and hospitalizations have slowed since the peak this winter, they are still significant. **In fact, caseloads and hospitalizations are once again increasing in certain areas of the country.** For example, for the week ending June 20, cases in nine states increased week-over-week; cases in four of these states increased by double digits, and one by over 35%.[1] Hospitalizations in 11 states increased week-over-week, with several states increasing by double digits.[2] There are 12 states still experiencing intensive care unit (ICU) occupancy rates of 75% or more, with three states over 80%.[3] The Centers for Disease Control and Prevention classifies eight states as having "substantial" transmission of COVID-19, and continues to classify several areas of the U.S. as "hotspots" or "sustained hotspots."[4] Further, experts continue to warn that the more contagious delta variant combined with lower vaccination rates in certain areas of the country could spur a fall and winter surge in COVID-19 cases.

Accordingly, hospitals and health systems continue the battle against COVID-19. They continue to incur expenses related to these COVID-19 cases and hospitalizations, such as to ensure an adequate workforce. COVID-19 has taken a heavy toll on our health care heroes, who have been on the front lines of the pandemic with many suffering from trauma, burnout and increased behavioral health challenges. A number of hospitals have experienced critical staffing issues due to the demands of surges of very ill COVID-19 patients, as well as assistance in helping control the pandemic through testing, contact tracing and vaccine deployment. In addition, expenses to acquire equipment and supplies such as personal protective equipment, pharmaceuticals and safety equipment, and maintaining testing and additional screening for every hospital patient continue. Hospitals and health systems must be able to apply their PRF money toward these costs, which they will undoubtedly continue to incur beyond June 30 and through the end of the PHE, without regard to when the funds were originally received.

---

[1] https://graphics.reuters.com/HEALTH-CORONAVIRUS/USA-TRENDS/dgkvlgkrkpb/.
[2] Ibid.
[3] https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9.
[4] Ibid.

Finally, the Administration itself yesterday recognized that COVID-19 is an ongoing threat when it published its Occupational Safety and Health Administration Emergency Temporary Standard requiring certain health care employers to develop and implement a plan to identify and control COVID-19 hazards in the workplace. Hospitals and health systems will need to meet new requirements within the next 30 days, resulting in additional COVID-19-related expenses for providers.

Again, we question the policy rationale for using the PRF payment date as a basis for the spending deadline. For example, as summarized in the table below, HHS made a $10 billion distribution to rural facilities in early May 2020; these providers must spend these funds by June 30, 2021. It made a $1 billion distribution to additional rural facilities in mid-July 2020; these providers have until Dec. 31, 2021 to spend these funds. These payments were made to similar providers only about two months apart, yet one group has six months less to spend the funding. As another example, HHS made a $10 billion distribution to hospitals serving high numbers of Medicaid and uninsured patients in early June 2020; these providers must spend these funds by June 30, 2021. It made a $3 billion distribution to additional hospitals serving high numbers of Medicaid and uninsured patients in mid-July 2020; these providers have until Dec. 31, 2021 to spend these funds. These payments were made to similar providers only about one month apart, yet one group has six months less to spend the funding. Finally, HHS began making its “Phase 3” application-based payments at the end of December 2020, with distributions stretching into 2021. Providers who received their payment on Dec. 31, 2020 have until Dec. 31, 2021 to spend the funds. Providers who received their payment on Jan. 1, 2021 have until June 30, 2022 to spend the funds. Thus, the exact same type of payment being made just one day sooner results in a provider having six months less to spend the funding.

Distribution	**Date Payment Made**	**Deadline to Spend**
Rural	Early May 2020	June 30, 2021
	Mid-July 2020	Dec. 31, 2021
High Medicaid and Uninsured	Early June 2020	June 30, 2021
	Mid-July 2020	Dec. 31, 2021
Phase 3 Application	Dec. 2020	Dec. 31, 2021
	Early 2021	June 30, 2022

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

Again, we appreciate the actions recently taken to provide an extension and respectfully request additional flexibility so that we can effectively serve our patients and community.

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/

Richard J. Pollack
President and Chief Executive Officer