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NATIONAL RURAL HEALTH ASSOCIATION

June 17, 2021

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

RE: The Department of Health and Human Services' June 11, 2021, Revised Notice of Reporting Requirements and Reporting Timeline for Recipients of Provider Relief Fund Payments.

Dear Secretary Becerra,

On behalf of the National Rural Health Association (NRHA), I want to express our deep disappointment with the Department of Health and Human Services' (HHS) guidance for health care providers utilization of Provider Relief Fund (PRF) allocations updated June 11, 2021.

NRHA is a non-profit membership organization with more than 21,000 members that provides national leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, Critical Access Hospitals (CAHs), doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

Despite extensive outreach about the challenges facing rural providers due to HHS' interpretation of lost revenues, capital expenditures, and other reporting requirements under the PRF, the Administration continues to implement the program in a manner that will likely require hundreds of rural providers to return funds to the Department of the Treasury. **NRHA urges you to take immediate steps to ensure the PRF dollars support rural providers combatting the ongoing COVID-19 pandemic.**

In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which appropriated funds to reimburse eligible health care providers for "health care related expenses or lost revenues that are attributable to coronavirus" through the PRF. The program has assisted health care providers fighting the COVID-19 pandemic, but many in rural America are not able to utilize their allocations as Congress intended. The updated HHS guidance release on June 11, 2021, does not include changes rural providers need to ensure the funding provides required stability, mainly: **1) use of funds past June 30, 2021, for Phase 1 recipients, 2) use of capital resources based on contract status (rather than completion) as of June 30, 2021, 3) modifications to reporting requirements for cost-based providers** (including CAHs, Rural Health Clinics (RHCs), and rural Federally Qualified Health Centers (FQHCs)).
Rural America has been crippled by a hospital closure crisis for more than a decade, which has worsened during the pandemic. **Since 2010, 138 rural hospitals have shuttered their doors with**

more than 20 occurring in 2020, many at the peak of the COVID-19 pandemic. It is unfathomable that a significant portion of this lifeline program, designed by Congress to support struggling providers, will ultimately be returned to the Treasury instead of helping rural communities combat the ongoing COVID-19 pandemic. Further, while the COVID-19 vaccine has slowed the spread of the virus nationwide, some rural communities are still seeing surges in cases due to lower vaccination rates. For many rural providers on the frontlines, the end of the public health emergency is not in sight. Loss of this funding will hurt rural providers that have historically operated on slim-to-negative margins, and it will hinder communities still struggling with the virus from getting through to the other side.

NRHA firmly believes Congress intended for PRF dollars to be utilized by health care providers to fight COVID-19, not sit in bank accounts only to be later repaid to the Treasury due to implementation challenges. We acknowledge and appreciate the important role of program integrity in execution of the PRF. Unfortunately, however, many of the policies and reporting guidelines issued thus far have substantial negative implications for rural safety-net providers. **Below are further suggestions for the Department to ensure that PRF dollars provide support to rural providers, consistent with the recommendations NRHA shared with the Department in February and again in May 2021.**

Timeline for Use of Funds

As stated above, many rural providers are still struggling with the COVID-19 pandemic, and will continue to struggle beyond June 30, 2021, as recognized by the Department's continuation of the national public health emergency declaration. In many rural areas, COVID-19 infection rates remain higher than their urban counterparts due to lower vaccination rates. According to the Centers for Disease Control and Prevention (CDC), the current seven-day case rate per 100,000 people is greater in rural (non-metro) areas (5.4) than in urban (metro) areas (4.39).[1] Additionally, urban (metro) areas have a 7.5 percent higher vaccination rate than rural (non-metro) areas.[2]

Therefore, NRHA requests that HHS allow rural providers to continue to use needed PRF funds past the proposed date of June 30, 2021. Rural providers had less than three weeks' notice from HHS' enforcement of the June 30, 2021, deadline for use of funds. The distribution of $10 billion to 8,351 rural facilities, including rural acute general hospitals and CAHs, RHCs, and FQHCs located in rural areas, remain subject to a deadline of June 30, 2021, for resources to be allocated. Given the inconsistent HHS guidance, and the ambiguity it has created, many rural providers have waited to expend funds. For all intents and purposes, rural providers agreed to the terms and conditions associated with the federal dollars to make a safer environment for staff and patients, but the continued changes to HHS guidance, and now limited notice of the revised reporting requirements, leaves many unsure what to do. Sadly, NRHA expects a large swath of rural providers will have to return their lifeline payments of $1-3 million to the Treasury Department, while still on the frontlines of the fight against COVID-19.

Capital Expenditures

Many rural hospitals have embarked on capital projects, including constructing or remodeling facilities to meet the needs of COVID-19. These projects often require planning, bidding, and lengthy construction or implementation phases. In addition, many manufacturers and construction firms are experiencing supply chain issues and staffing issues (particularly in the construction sector) that have resulted in project delays way beyond what could be reasonably expected before the pandemic. The

[1] https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7020e3-H.pdf
[2] https://dailyyonder.com/15-states-pass-the-40-threshold-for-rural-vaccinations/2021/06/10/

construction industry lost nearly 15 percent of its workforce during the pandemic, most of which has not returned to work, which was exacerbated in many rural communities where there are fewer firms.[3] Further, because of the late release of updated guidance, it will be impossible for rural providers to fully allocate, or have their construction projects completed, in accordance with the June 30, 2021, deadline.

NRHA requests that capital expenditures that are under contract by June 30, 2021, be allowable under PRF requirements in their entirety to accommodate essential activities that may not be completed by the current deadline. Additionally, NRHA requests the total cost of these capital items be permitted as COVID-19 related expenses and reported in the period of availability which the provider entered into the contract, regardless of when the projected is completed or when the payment is made. Further, accounting of capital costs has unique considerations for cost-based providers. There is precedent for HHS using an approach for capital projects under contract with rural providers per the Medicare Provider Reimbursement Manual, Chapter 28 Prospective Payments[4], that could be used as language for the HHS guidance.

Modifications to Current Reporting Guidelines for Cost-Based Providers

Many rural providers are paid under cost-based reimbursement, including CAHs, RHCs, and FQHCs. Cost reporting, associated with cost-based reimbursement, is complex and presents several challenges in determining expenses attributable to COVID-19 related to use of PRF funds, as well as the determination of lost revenue.

Capital Related Costs: **NRHA requests that capital cost should not be reduced by estimated *future* cost-based reimbursement for depreciation for cost-based providers**. Future reimbursement for depreciation should be in the category of "those that are unreimbursed by other sources and that other sources are not obligated to reimburse" (Notice page 9, item 8).

***COVID-related Revenues*:** Rural providers, particularly hospitals, had a significant surge in COVID-19 patients during the last half of 2020 and, into early 2021. HHS guidance states that, in the calculation of COVID expenses, such expenses are reduced by the related revenues (reimbursement received for services to these patients). It appears the related patient revenues for this surge in patients may have a doubly negative impact on providers under current guidance. **For cost-based providers, COVID-19 revenues used to reduce COVID-19 expenses should not be included in 2020 or 2021 revenues for any lost revenue calculations.** Reimbursement for services to COVID-19 patients logically would reduce the related COVID-19 expenses. However, such reimbursement should not also be included in overall patient revenues for 2020 or 2021 when compared to 2019 or budget revenues. Including COVID-19 patient revenues (i.e., reimbursement) in the lost revenue calculation inappropriately doubles the impact on providers if that reimbursement has already been included in the COVID-19 expense calculation.

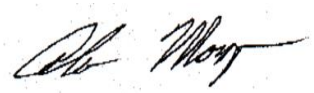
NRHA asks the Department to take the necessary actions to ensure that providers still struggling with the pandemic are able to leverage their PRF allocations to support their communities as soon as possible. Further, we look forward to working with you on allocation of the $8.5 billion Health Care Heroes Sustainability Fund (HCHSF) for health care providers, specifically those serving rural America.

[3] https://www.procore.com/jobsite/a-look-at-how-covid-19-changed-the-construction-industry-in-2020-and-beyond/
[4] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P151_28.zip Section 2807.3, Section C, page 23.

Ensuring that these dollars are implemented consistent with congressional intent and being used to safeguard, rather than jeopardize, access to care in rural communities across the country is critical.

Thank you for your work on the PRF program. If you would like additional information, please contact Carrie Cochran-McClain at ccochran@nrharural.org or 202-683-2701.

Sincerely,



Alan Morgan
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