VIA EMAIL

April 5, 2021

Diana Espinosa, Acting Administrator
Health Resources and Services Administration
US Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Acting Administrator Espinosa:

The Critical Access Hospital Coalition, with critical access hospitals (CAHs) across the country, writes to request that HRSA reconsider its FAQ on the Provider Relief Fund (PRF) modified on February 24, 2020 regarding the relationship between cost-based reimbursement and the PRF.

CAHs operate on a narrow margin in the best of times and few are able to absorb the additional costs required to prepare for and treat patients with COVID-19. Congress had the foresight to address this financial strain by appropriating additional funds to be distributed to health care providers, including CAHs, through the PRF. HRSA's interpretation of how providers with cost-based reimbursement may use the PRF payments appears to leave CAHs in the position of essentially floating a loan to the government until we are reimbursed by CMS through the routine cost reporting process. This will increase the financial pressures on CAHs, potentially leading to more closures at a time when the demands on health care facilities and providers are greater than ever.

The FAQ at issue states:

> How does cost-based reimbursement relate to my Provider Relief Fund payment? (Modified 2/24/2021)
> Recipient must follow CMS instructions for completion of cost reports available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.
>
> Under cost-based reimbursement, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. In these instances, if the full cost was reimbursed based upon this method, there is nothing eligible to report as an expense attributable to coronavirus because the expense was fully reimbursed by another source. Provider Relief Fund payments cannot be used to cover costs that are reimbursed from other sources or that other sources are obligated to reimburse. Therefore, if Medicare or Medicaid makes a payment to a provider based on the provider's cost, such payment generally is considered to fully reimburse the provider and no money from the PRF would be available. However, in cases where a ceiling is applied to the cost reimbursement and the reimbursed amount by Medicare or Medicaid does not fully cover the actual cost due to unanticipated increases in providing care

attributable to coronavirus, those incremental costs that were not reimbursed are eligible for reimbursement under the Provider Relief Fund.

The practical application of this FAQ for many CAHs, with a significant Medicare/Medicaid population, means that the costs we incurred due to COVID-19 for our Medicare/Medicaid population will be placed on our cost reports to be reimbursed in the normal course of business. It can be several years before final settlement of a cost report. Meanwhile, in July of this year, we must account for expenditures and return "unused" PRF. Based on this FAQ, CAHs will be expected to return much, if not most, of the PRF payments since we are able to retain funds only for the percentage of our patient population who are not Medicare or Medicaid patients. In the interim we will have provided the services, purchased the PPE and extra equipment, retained the services of extra health care providers, etc., for our entire patient population.

The approach outlined in the FAQ creates a financial shortfall for CAHs with a significant Medicare/Medicaid population, at least until such time in the future when the cost report is settled. We urge HRSA to reconsider this approach. One alternative would be to allow CAHs and other providers that are reimbursed on a cost basis to use the PRF payments for their COVID-19 costs – with reporting and repayment as required by the PRF – and not include the same expenses on the cost report, perhaps indicating on the cost report the expenses have already been reimbursed through the PRF. This would ensure no "double dipping" as required by the CARES Act, and it would allow CAHs to use the PRF as intended and not be caught short while awaiting Medicare/Medicaid cost-based reimbursement from CMS. This approach would have to be structured in a way that would not impact CMS rate letters for Medicare Advantage.

We request an opportunity to meet with your designee to discuss this request further. Please contact 5444 or diane.turpin@shcare.net, to schedule a call.

Thank you for your prompt attention to our concerns. We note that July is rapidly approaching and trust that a resolution may be found before CAHs are required to report.

Sincerely,

Alabama
Choctaw General Hospital

Alaska
Kanakanak Hospital

Arkansas
Bradley County Medical Center
CHI St Vincent Morrilton
Delta Memorial Hospital
Howard Memorial Hospital
Ozarks Community Hospital

California
Catalina Island Medical Center
Modoc Medical Center

Colorado
Centura Health-St. Thomas More Hospital
Memorial Regional Hospital
Sedgwick County Memorial Hospital

Georgia
Elbert Memorial Hospital

Idaho
Bingham Memorial Hospital

Illinois
OSF Holy Family Medical Center
OSF Saint Luke Medical Center (FKA Kewanee Hospital)

OSF Saint Paul Medical Center (FKA Mendota Community Hospital)
Clay County Hospital

Indiana
Pulaski Memorial Hospital

Iowa
Loring Hospital

Kansas
Decatur Health
Morris County Hospital
Smith County Memorial Hospital

Louisiana
Union General Hospital
Riverside Medical Center

Michigan
OSF St Francis Hospital

Minnesota
Big Fork Valley
RiverView Health

Mississippi
Greene County Hospital
Scott Regional Hospital
Laird Hospital
John C. Stennis Memorial Hospital
H.C. Watkins Memorial Hospital
Perry County General Hospital
North Sunflower Medical Center

Nebraska
Community Memoria Hospital
Gordon Memorial Hospital District
Howard County Medical Center
Osmond General Hospital

Ohio
Wyandot Memorial Hospital

Oklahoma
Coal County General Hospital
Fairview Regional Medical Center
Okeene Municipal Hospital

Washington
Pullman Regional Hospital
Skyline Health