January 19, 2022

The Honorable Joseph R. Biden
President of the United States
The White House
Washington, DC 20500-0005

Honorable Charles E. Schumer
Majority Leader
United States Senate

Honorable Mitch McConnell
Republican Leader
United States Senate

Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives

Honorable Kevin McCarthy
Republican Leader
U.S. House of Representatives

Dear Mr. President and Congressional Leaders:

We are very grateful for your ongoing leadership and support during the COVID-19 pandemic. From providing billions of dollars in financial support, regulatory relief and community resources – including boots on the ground – to support our caregivers, your response has been extremely significant. However, the reality is still stark and additional help is needed as we face yet another nation-wide surge of the virus.

Critical staffing shortages are crippling our response efforts. We have all diverted some non-clinical staff to support our clinicians across all patient care settings, while we simultaneously continue to support community vaccination efforts and ongoing needs. The need for clinical and non-clinical staff in our hospitals, driven by unprecedented patient volume and severity, is dramatically increasing the cost of providing care in our health systems. These developments have brought our national health system to the brink.

If one-third of the population across the United States remains unvaccinated, then the government must take extraordinary action to assure the short- and long-term viability of the nation's health care system.

To help us, we are recommending the following policy changes that will take both Congressional and Administrative actions (several recommendations have already been introduced in Congress):

- Delay implementation of Medicare sequestration through July 1, 2022
- Delay Medicare loan repayments for a year. (H.R.2407)
- Update DRG payment for COVID to reflect the longer length of stay
- Provider Relief Fund:
    - Distribute remaining funds to providers no later than March 31, 2022. Focus payments on staffing costs (budgeted vs actual from April 1, 2021 to March 1, 2022)
    - Increase fund by $20 billion
    - Delay reporting requirements by six (6) months
- Allow FEMA to reimburse for direct *and* indirect clinical staffing costs related to COVID

- Reinstate hospitals that have lost their 340B status due to the pandemic. (S. 773)
- Protect current nurse and allied health workforce funding (H.R. 4407 / S.1568)
- Delay for six (6) months Cares Act Reporting 2 deadline of March 31, 2022 and Medicare Cost Reporting deadlines of May 30, 2022.
- Delay implementation or enforcement of Surprise Billing regulations (particularly 'good faith estimate' requirements) until January 2023.
- Delay enforcement of hospital price disclosure requirements until January 2023.

(We have attached a two-page Fact Sheet that provides additional details on these requests.)

We ask Congress and the Administration to act on these and other relief initiatives by mid-February. This will help ensure a viable national health care system as the pandemic continues.

Sincerely,

Health Systems
Adventist HealthCare, Maryland
Adventist Health, California
Allina Health, Minnesota
Atrium Health, North Carolina, Georgia, Alabama
Aultman Health, Ohio
Avera Health, South Dakota, Iowa, Minnesota, Nebraska
Baptist Health, Kentucky
BJC HealthCare, Missouri
Bon Secours Mercy Health, Kentucky, Ohio, South Carolina, Virginia
Bryan Health, Nebraska
CarePoint Health System, New Jersey
CentraCare, Minnesota
CenturaHealth, Colorado, Kansas
ChristianaCare, Delaware
Comanche County Hospital Authority, Oklahoma
CoxHealth, Missouri
CommonSpirit Health, Illinois
Community Hospital Corporation, Texas
Crouse Hospital, New York
FirstHealth of the Carolinas, North Carolina, South Carolina
Genesis HealthCare System, Ohio
Hackensack Meridian Health Network, New Jersey
Inspira Health Network, New Jersey
Jefferson Health, New Jersey, Pennsylvania
Kettering Health, Ohio
Legacy Health, Oregon, Washington
Lehigh Valley Health Network, Pennsylvania
Loma Linda University Health, California
Mary Washington Healthcare, Virginia
Methodist Le Bonheur Healthcare, Tennessee

Mon Health, West Virginia
Mosaic Life Care, Missouri
Mountain Health Network, West Virginia
MultiCare Health System, Washington
Norton Healthcare, Kentucky
Northeast Alabama Regional Medical Center, Alabama
Northeast Georgia Health System, Georgia
OSF Health, Illinois, Michigan
Perimeter Healthcare, Louisiana
Piedmont Health, Georgia
Presbyterian Healthcare Services, New Mexico
ProMedica, Ohio, Michigan
Renown Health, Nevada
Sisters of Charity Health System, Ohio
St. Vincent Charity Medical Center, Ohio
SSM Health, Missouri, Oklahoma, Wisconsin, Illinois
The Queen's Health Systems, Hawaii
UR Medicine, New York
Valley Health, Virginia, West Virginia
Valleywise Health, Arizona

Independent/PPS Hospitals
Baptist Hospitals of Southeast Texas – Beaumont, Texas
Baptist Hospitals of Southeast Texas – Orange Campus, Texas
Blount Memorial Hospital, Tennessee
Bothwell Regional Health Center, Missouri
Carolinas ContinueCARE Hospital at Pineville, North Carolina
Carolinas ContinueCARE Hospital at University, North Carolina
Community Hospital, Colorado
ContinueCARE Hospital at Baptist Health Corbin, Kentucky
ContinueCARE Hospital at Baptist Health Madisonville, Kentucky
ContinueCARE Hospital at Baptist Health Paducah, Kentucky
ContinueCARE Hospital at Hendrick Medical Center, Texas
ContinueCARE Hospital at Medical Center (Odessa), Texas
ContinueCARE Hospital at Palmetto Health Baptist, South Carolina
Enloe Medical Center, California
Fairfield Medical Center, Ohio
Fisher-Titus Health, Ohio
Freestone Medical Center, Texas
Gaylord Hospital, Connecticut
Grove Creek Medical Center, Idaho
Highland-Clarksburg Hospital, West Virginia
Holy Name, New Jersey
Huntsville Memorial Hospital, Texas
Knox Community Hospital, Ohio

Madison Health, Ohio
Magee General Hospital. Mississippi
McAlester Regional Health Center, Oklahoma
Memorial Hospital of Sweetwater County, Wyoming
Niagara Falls Memorial Center, New York
North Texas Medical Center, Texas
Pacifica Hospital of the Valley, California
Panola Medical Center, Mississippi
Pomerene Hospital, Ohio
Shepherd Center, Georgia
Specialty Hospital of Lorain, Ohio
St. Anthony Regional Hospital, Iowa
St. Mark's Medical Center, Texas
St. Rose Hospital, California
Stilwell Memorial Hospital, Oklahoma
The Loretto Hospital, Illinois
Totally Kids Rehabilitation Hospital, California
Tyler ContinueCARE Hospital, Texas
University Medical Center (UMC) of Southern Nevada, Nevada
Winona Health, Minnesota
Wilson N. Jones Regional Medical Center, Texas
Wood County Hospital, Ohio

Critical Access Hospitals

Bingham Memorial Hospital, Idaho
Calais Community Hospital, Maine
Colorado Canyons Hospital, Colorado
Cheyenne County Hospital, Kansas
Clarke County Hospital, Iowa
Cogdell Memorial Hospital, Texas
Covington County Hospital, Mississippi
Down East Community Hospital, Maine
Fulton County Health Center, Ohio
George E. Weems Memorial Hospital, Florida
Grafton City Hospital, West Virginia
Good Shepherd Health Care System, Oregon
Gordon Memorial Hospital District, Nebraska
Haxtun Hospital District, Colorado
Hocking Valley Community Hospital, Ohio
Holy Cross Medical Center, New Mexico
Howard County Medical Center, Nebraska
Iron County Medical Center, Missouri
Johnson County Hospital, Nebraska
Kanakanak Hospital, Alaska
Kiowa County Hospital District, Colorado
Kit Carson County Health Service District, Colorado
Liberty Regional Medical Center, Georgia
Longleaf Hospital, Louisiana
Macon Community Hospital, Tennessee
Magruder Memorial Hospital, Ohio
Memorial Medical Center, Texas
Mount Desert Island Hospital, Maine
North Shore Health, Minnesota
North Sunflower Medical Center, Mississippi
Northern Inyo Healthcare District, California
Osceola Medical Center, Wisconsin
Ozarks Community Hospital, Arkansas
Pioneer Medical Center, Montana
Putnam County Memorial Hospital, Missouri
Putnam General Hospital, Georgia
Quitman Community Hospital, Mississippi
Ray County Memorial Hospital, Missouri
Riverside Medical Center, Louisiana
RiverView Health, Minnesota
Sedgwick County Health Center, Colorado
Simpson General Hospital, Mississippi

Skyline Health, Washington
Snoqualmie Valley Hospital, Washington
Southeast Colorado Hospital District, Colorado
Stanton County Hospital, Kansas
The New Roseland Community Hospital, Illinois
Tippah County Hospital, Mississippi
Union County General Hospital, New Mexico
Vernon Memorial Healthcare, Wisconsin
Welia Health, Minnesota
Wyandot Memorial Hospital, Ohio
Yoakum Community Hospital, Texas
Yuma District Hospital and Clinics, Colorado
Rio Grande Hospital, Colorado
Ward Memorial Hospital, Texas

Other Health Care Providers
Tarzana Treatment Centers Inc., California

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FACT SHEET
Hospital and Health System Recommendations to the President and Congress for Additional Covid relief

- Delay implementation of Medicare sequestration through July 1, 2022

Congress enacted legislation in December 2021 that delayed Medicare sequestration through March 31, 2022 and reduced sequestration to 1% through June 30, 2022. Reducing sequestration another 1% from April 1, 2022 through June 30, 2022 would provide additional resources to all hospitals.

- Delay Medicare loan repayments (H.R. 2407)

Many providers have already begun repaying Medicare loans or have fully repaid them. Halting the repayment process for one year will allow those providers needing additional resources to keep the cash on hand to help finance the increased costs they are currently experiencing. All funds will be repaid to the Medicare Trust Fund. H.R. 2407 would implement this request.

- Provider Relief Fund:
    - Distribute remaining funds to providers no later than March 31, 2022. Focus payments on staffing costs (budgeted vs actual from April 1, 2021 to March 1, 2022)

Phase 4 payments are projected to be completed in early 2022, leaving approximately $25 billion remaining in the PRF. Those are both obligated and unobligated funds. Congress should reclassify all these funds as unobligated. Distribution should target staffing cost increases associated with Covid care based on budgeted vs. actual amounts between April 1, 2021 and March 1, 2022. Most staffing cost increases for Covid care were incurred during this time. Phase 4 PRF payments are for Covid expenses and losses for the period ending March 31, 2021. There have been NO PRF payments for Covid losses and expenses for the period after March 31, 2021.

    - Increase fund by $20 billion

The initial funding amount of $175 billion did not anticipate an additional year of increasing case numbers. The additional funding will give HHS flexibility in addressing unanticipated Covid expenses and losses.

    - Delay reporting requirements by 6 months

Delaying the reporting requirements and allowing providers to continue to utilize existing payments for an additional six months will help providers until additional funding is provided and Covid cases begin to subside. Additionally, a delay in reporting will reduce the burden on staff at a time when staff resources are stressed.

- Update DRG payment for Covid to reflect the longer length of stay

The DRG for Covid payments has not been updated in more than a year. Covid patients are staying in the hospital far longer than what had been anticipated when the reimbursement and add-on payments were created. The current 20% add-on does not cover the additional costs. The payment must be updated to better align the resource costs with extended stays.

- Allow FEMA to reimburse for direct and indirect clinical staffing related to Covid

Relax FEMA regulatory requirements that restrict FEMA staff from providing any care for patients who are not Covid patients; some de minimis care for non-Covid patients would prioritize patient care. Currently, hospitals cannot use even a minute of FEMA staff time, i.e. moving a non-Covid patient from a hospital room to make more space for a Covid patient, without keeping detailed logs

of FEMA staff use and non-Covid utilization cannot be reimbursed. This burdensome requirement consumes considerable staff time.

- Reinstate hospitals that have lost their 340B status due to the pandemic. (S. 773)

A growing number of 340B hospitals' DSH percentages fell below 11.75 percent due to the ongoing pandemic, leading to the loss of their 340B status for a full year. S. 773 would ensure that DSH hospitals can maintain 340B status through the public health emergency or reinstate their 340B program status if already lost.

- Protect current nurse and allied health workforce funding (H.R. 4407 / S.1568)

Because of a CMS error made over the past 20 years, hospital-based schools of nursing and allied health professionals are getting a substantial payment reduction – jeopardizing the future of these programs. This will reduce the number of nurses and allied health professionals. About a third of these programs serve rural areas.

- Delay for six months Cares Act Reporting 2 deadline of March 31, 2022 and Medicare Cost Reporting deadlines of May 30, 2022.

Each of these deadlines are dependent upon Financial Statements and other critical documents. Hospitals are redeploying team members to support the frontline, including staff from the finance department. As a result, financial statements could be delayed as well as other critical documents needed to complete these reports. Preparation of these documents takes place in January and February, thus the immediate need for an extension.

- Delay implementation or enforcement of Surprise Billing Regs (particularly 'good faith estimate' requirements)
- Delay enforcement of hospital price disclosure requirements

The surprise billing regulations are effective January 1, 2022, and we are waiting for additional regulations and guidance for parts of the law, including the good faith estimate requirements for all patients. Additionally, the hospital price disclosure regulations are effective January 1, 2022. Providers are spending significant amount of staff time and resources to prepare for compliance. These regulations are exceptionally complex, as recognized by HHS. To ensure seamless implementation requires more time and resources, which are not available during the pandemic