UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Exhibit	Description	Page(s)
A	Declaration of Jeffrey M. White	App.001–004
A-1	Julian Gill, 'We are in a crisis': Houston nursing shortage comes to a head as 'onslaught' of patients swarm LBJ hospital	App.005–016
A-2	Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery – Results of National Pulse Survey, February 22–26, 2021, U.S. Department of Health and Human Services Office of Inspector General	App.017–079
A-3	Lauren Margolis, State deploys nurses to help East Texas hospitals with staffing shortages	App.080–095
A-4	Governor Abbott Takes Action to Expand Nursing Workforce	App.096–098
A-5	Texas Physician Supply and Demand Projections, 2018 – 2032	App.099–151
A-6	Press Briefing by Press Secretary Jen Psaki, The White House (July 23, 2021)	App.152–179

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CERTIFICATE OF SERVICE

I certify that a true and accurate copy of the foregoing document was filed electronically (via CM/ECF) on November 16, 2021. The foregoing document was also served electronically on counsel for Defendants on November 16, 2021, although counsel for Defendants has not agreed to accept electronic service. I further certify that a true and accurate copy of the foregoing document will be served by mail on the following recipients on November 17, 2021:

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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

VOLUME I OF I

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DECLARATION OF JEFFREY M. WHITE

EXHIBIT A

UNITED STATES DISTRICT COURT
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AMARILLO DIVISION

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DECLARATION OF JEFFREY M. WHITE IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Jeffrey M. White, hereby declare as follows:

1. I am over 18 years of age and am fully competent to make this declaration. I am Special Counsel in the Special Litigation Unit at the Office of the Attorney General of Texas, I am admitted to practice law in this Court, and I represent Plaintiffs in the above-captioned matter. I submit this Declaration in support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction. I have personal knowledge of the facts stated herein.

2. Appended to Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction are the following exhibits:

Ex. No.	Title
1	Julian Gill, *'We are in a crisis': Houston nursing shortage comes to a head as 'onslaught' of patients swarm LBJ hospital*, THE HOUSTON CHRONICLE (Aug. 4, 2021), which is publicly available at https://www.houstonchronicle.com/news/houston-texas/health/article/Houston-nursing-shortage-comes-to-a-head-as-16361747.php.

2	The report titled "Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery – Results of a National Pulse Survey, February 22–26, 2021, published by the U.S. Department of Health and Human Services Office of Inspector General, which is publicly available at https://oig.hhs.gov/oei/reports/OEI-09-21-00140.pdf.
3	Lauren Margolis, *State deploys nurses to help East Texas hospitals with staffing shortages*, KETK.com (Aug. 19, 2021), which is publicly available at https://www.ketk.com/news/health/coronavirus/state-deploys-nurses-to-help-east-texas-hospitals-with-staffing-shortages/.
4	A press release from Texas Governor Greg Abbott on March 21, 2020, titled "Governor Abbott Takes Action to Expand Nursing Workforce," which is publicly available at https://gov.texas.gov/news/post/governor-abbott-takes-action-to-expand-nursing-workforce.
5	A report titled "Texas Physician Supply and Demand Projections, 2018 – 2032," dated May 2020, which is publicly available at https://www.dshs.state.tx.us/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf.
6	Press Briefing by Press Secretary Jen Psaki, The White House (July 23, 2021), which is publicly available at https://www.whitehouse.gov/briefing-room/press-briefings/2021/07/23/press-briefing-by-press-secretary-jen-psaki-july-23-2021/.
7	Remarks by President Biden on Fighting the COVID-19 Pandemic, The White House (Sept. 9, 2021), which is publicly available at https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/.
8	The Centers for Disease Control and Prevention's COVID Data Tracker, COVID-19 Vaccinations in the United States, which is publicly available at https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.
9	CDCHAN-00447: Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021 (July 27, 2021), which is publicly available at https://emergency.cdc.gov/han/2021/han00447.asp.
10	A Centers for Disease Control and Prevention website titled "COVID-19 Vaccines That Require 2 Shots," which is publicly available at

	https://www.cdc.gov/coronavirus/2019-ncov/vaccines/second-shot.html#second.

3. The exhibits listed above are true and correct copies of what they purport to be.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 16, 2021

/s/ Jeffrey M. White
Jeffrey M. White

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DECLARATION OF JEFFREY M. WHITE

Julian Gill, *'We are in a crisis': Houston nursing shortage comes to a head as 'onslaught' of patients swarm LBJ hospital*, THE HOUSTON CHRONICLE (Aug. 4, 2021)

EXHIBIT A-1

Most Popular

1. 9-year-old Ezra Blount becomes 10th person to die in Astroworld
2. Houston Methodist suspends River Oaks doctor for spreading...
3. Stories of Astroworld: Concertgoers look back on tragedy
4. Befc Scot Sun

LOCAL // HEALTH

'We are in a crisis': Houston nursing shortage comes to a head as 'onslaught' of patients swarm LBJ hospital

Julian Gill, Staff writer

Updated: Aug. 4, 2021 7:47 p.m.

1 of 3

Lyndon B. Johnson Hospital, 5656 Kelley St., Monday, Dec. 16, 2019, in Houston.

Steve Gonzales, Houston Chronicle / Staff photographer

Houston nurse Jacquelyn Bhones manages the stress of her workday with 10-minute "microbreaks," sipping water in a quiet room until she has to return to her patients.

Bhones, 43, has been treating COVID-19 patients at a Houston hospital throughout the pandemic, sometimes working up to 60 hours a week amid a nursing shortage and numerous surges in virus-related hospitalizations.

"It's just been difficult," she said.

Her growing workload is part of a problem that healthcare providers are facing throughout the state and the Houston-area. A nationwide nursing shortage that started before the pandemic – coupled with nurses who retired, left the profession or are quarantining from COVID infections – has further strained hospitals dealing with a fourth surge of patients battling the virus. The shortage came to a head this weekend when Lyndon B. Johnson Hospital in Houston was forced to declare an "internal disaster", briefly halting ambulance traffic as emergency room wait times swelled to 24 hours.

COVID HELP DESK: What you need to know about the delta variant

While the state sent additional nurses to help during previous surges, this time it is directing city and county governments to make use of federal dollars through the Coronavirus Local Fiscal Recovery Funds. In a June 29 letter to mayors and county judges, the Texas Division of Emergency Management said the funds are available to boost hospital staffing and increase pay for essential workers.

Meanwhile, nurses on the front lines "are burned out," Texas Nurses Association CEO Cindy Zolnierek wrote in a letter to the public last week.

"We are all tired of this; nurses are tired of this," she said.

‘A terrible disaster’

The shortage has come into clearer view while Texas deals with an acute surge of COVID-19 hospitalizations. On Wednesday, the state reported 7,685 hospitalizations, up from 7,305 on Tuesday and an increase of 35.7 percent from a week ago. The Texas Medical Center is admitting about 281 patients per day – the majority of which are unvaccinated – compared to 246 last week and 51 last month.

Harris Health System needs about 250 nurses to fully staff LBJ and Ben Taub hospitals. University of Texas Medical Branch in Galveston recently requested about 100 nurses from staffing agencies for its four hospitals. The shortage has contributed to a backlog of 279 patients waiting for a general bed and 35 patients waiting for an ICU bed at hospitals throughout the nine-county region that includes Houston, according to the Southeast Texas Regional Advisory Council.

The extent of the problem is less clear at Texas Medical Center hospitals. An internal memo at Houston Methodist Hospital said it “is struggling with staffing as the numbers of our COVID-19 patients rise,” but spokeswoman Gale Smith said a hiring bump this year has allowed the hospital to operate at full capacity.

Vanessa Astros, a spokeswoman for Baylor St. Luke's Medical Center, said the hospital “is definitely being impacted” but could not immediately provide staffing numbers. Memorial Hermann also could not provide staffing numbers by press time.

The severity of the nursing shortage at LBJ Hospital first came to light after an emergency room doctor emailed State Sen. John Whitmire Sunday night about the "untenable" situation there.

"The combined increase in volume from (COVID and) existing normal volume (and) nursing shortage has made this a terrible disaster at every ER and hospital in the city of Houston," the doctor wrote.

On HoustonChronicle.com: How COVID cost Houston $294 million in medical tourism dollars last year

Porsa said the hospital could only staff 16 of its 24 ICU beds. At one point, about 130 people were in the ER waiting room from an "onslaught" of patients with a variety of health problems. The hospital was no longer under an internal disaster by Monday but consistently remains at or near full capacity, he said.

"We are in a crisis situation," he said. "When you look at the rates and the rise of the number of COVID patients, it's not a curve. It's a straight line going up. This has never happened throughout the last year and a half in the pandemic. We have never seen this rapid of a rise in our COVID patients."

Featured COVID Stories

- Houston Methodist suspends River Oaks doctor for spreading COVID misinformation

- Tips to help make getting a COVID-19 vaccine less scary for kids

- COVID Help Desk: Will the U.S. authorize a pill to treat COVID-19 anytime soon?

- 'Would you get pregnant in a pandemic?' An essay from our (pregnant) COVID editor

- would you get pregnant in a pandemic? An essay from an (pregnant) editor

Read more related stories here

‘Multi-faceted problem’

The nursing shortage has been simmering for years, but the pandemic magnified the importance of the profession, said Dr. Kathleen Reeve, associate dean at the University of Houston College of Nursing.

Texas is projected to have a deficit of 59,970 nurses by 2030, according to state health data. An aging population and dwindling nursing school faculty has contributed to the problem, Reeve said. More nurses are retiring and nursing programs have limited capacity to accept students.

Additionally, the stress of the pandemic has pushed some nurses into other professions or to more lucrative jobs at agencies that place them at hospitals on a temporary basis.

“It’s a multi-faceted problem, and it’s not going to be anything that’s easily addressed,” Reeve said.

Staffing agencies in Houston are experiencing an uptick in requests from hospitals.

MedRelief Staffing CEO Jence Cantu said she is seeing more healthcare providers offering "crisis rates," or double the standard rate for the position.

"I do believe we will see more of the crisis rates being implemented, as they had been previously in the pandemic," she said.

Christina Cornealius, founder and CEO of CBC Medical Staffing in Houston, said her company has seen a roughly 75 percent increase in requests from healthcare

providers in the area.

"Due to the pandemic and fatigue, those (nursing) shortages have drastically increased and the weeks to come could pose some extraordinary challenges for healthcare workers and the community," she said.

Funding

The Houston-area benefited last year from an influx of hundreds of nurses from the state, which spent about $5.4 billion to contract with staffing firms to hire health care providers from April 2020 through June 2021. That money was reimbursed by the federal government. Porsa said the Harris Health System took on about 140 additional nurses from that effort.

On HoustonChronicle.com: How to talk to your loved ones about getting the COVID-19 vaccine

Now, Texas Department of State Health Services is highlighting more than $10 billion in federal money that is "available to pay for urgent COVID-19 response needs, including medical surge staffing," said health department spokesperson Chris Van Deusen. The city of Houston's allotment is $607 million, while Harris County's portion is $915 million, according to state records.

Local governments receive the money in two installments: Half in May, and half to be delivered next year, according to the U.S. Department of the Treasury. Houston city spokesperson Mary Benton said the city used about $198 million from the first allotment to fill the budget gap from the pandemic and stave off city staff cuts.About $10 million went to the Houston Zoo, which was affected by COVID, she said. She said information on the remaining funds was not available by press time.

Rafael Lemaitre, a spokesman for Harris County Judge Lina Hidalgo, said the county has earmarked most of the funds to support "immediate COVID needs" but did not know whether that included more nurses.

Darrell Pile, CEO of the Southeast Texas Regional Advisory Council, said many healthcare providers cannot quickly access the funds to hire more staff.

"The funds are not quickly accessible and the volume of patients are mounting as the shift in support from the state of Texas last Friday to local governments seems to have happened with little notice to local leaders," he said.

For Bhones, the Houston nurse, more funding could mean fewer shifts and more time to recover from the workday.

"You really don't have time for yourself," she said. "From when you first go to work, you're seeing COVID patients all day long."

julian.gill@chron.com

Written By
Julian Gill

Reach Julian on

Julian Gill is a reporter for the Houston Chronicle.

VIEW COMMENTS

REAL ESTATE

Hines mansion 'Adagio' in Houston's River Oaks relisted at $29.5 million

Take a virtual tour of a residence built for a magnate who developed The Galleria and knew real estate.

BY CHARLIE ZONG

IN CASE YOU MISSED IT

Jury awards $3.3 million to Massage Heights customer

Smith: After Astros' near-glory, a bleak winter for Houston fans

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DECLARATION OF JEFFREY M. WHITE

Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery – Results of a National Pulse Survey, February 22–26, 2021

EXHIBIT A-2

U.S. Department of Health and Human Services

Office of Inspector General

Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery

Results of a National Pulse Survey
February 22–26, 2021

Christi A. Grimm
Principal Deputy Inspector General

March 2021, OEI-09-21-00140

U.S. Department of Health and Human Services

Office of Inspector General

Report in Brief

March 2021, OEI-09-21-00140

Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery

Key Takeaways

In February 2021, hospitals reported that operating in "survival mode" for an extended period of time has created new and different problems than experienced earlier in the pandemic and exacerbated longstanding challenges in health care delivery, access, and health outcomes.

Hospital-Reported Challenges. Hospitals described difficulty balancing the complex and resource-intensive care needed for COVID-19 patients with efforts to resume routine hospital care. They reported that staffing shortages have affected patient care, and that exhaustion and trauma have taken a toll on staff's mental health. Administrators detailed challenges associated with vaccine distribution efforts and concerns about vaccine hesitancy among staff and members of their communities. Hospitals also raised concerns that the pandemic has exacerbated existing disparities in access to care and health outcomes. Additionally, many hospitals reported experiencing financial instability because of increased expenses associated with responding to a pandemic and lower revenues from decreased use of other hospital services. Hospitals indicated that many of the challenges were more severe for rural hospitals.

Addressing Hospital Challenges. Hospitals reported a range of strategies to address their challenges and identified areas in which further government support could help as they continue responding to the pandemic. Broadly, the areas of government support included enhancing knowledge and guidance on the prevention and treatment of COVID-19, including safe means to discharge patients with COVID-19; helping to fill gaps in hospital staffing, especially for nurses and certain specialists; continuing financial relief, especially to increase care to rural and underserved communities; and, encouraging widespread vaccinations to reduce the circulation of the virus.

Looking Forward. Beyond the immediate needs in responding to COVID-19, the pulse survey documents hospitals' perspectives about longer-term opportunities for improvement to address challenges that existed before, and were exacerbated by, the pandemic. These include reducing disparities in access to health care and in health outcomes; building and maintaining a more robust health care workforce; and strengthening the resiliency of our health care system to respond to pandemics and other public health emergencies and disasters.

Scope of the Review

This review provides a national snapshot, from the perspective of front-line hospital administrators, on how responding to the COVID-19 pandemic has affected their capacity to care for patients, staff, and communities. This is not a review of the HHS response to the COVID-19 pandemic. These hospital perspectives reflect a specific point in time—February 22–26, 2021—provided during a "pulse survey" (brief interviews) that OIG conducted with 320 hospitals nationwide. The timing was nearly a year after the World Health Organization declared COVID-19 to be a pandemic on March 11, 2020.

First Pulse Survey—March 2020

We conducted our first pulse survey of challenges that hospitals reported facing in response to COVID-19 during the early weeks of the pandemic. At that time, hospitals reported that they were largely focused on enhancing their capacity to respond to the pandemic. Hospitals reported challenges such as significant shortages in personal protective equipment (PPE), ventilators, and other supplies as demand increased across the country and around the globe. Hospitals also spoke of the challenge of needing to rapidly expand facility and staffing capacity. Finally, hospitals reported that, at the time, the lack of testing capability to detect which patients had COVID-19 negatively impacted hospital operations as they tried to prevent outbreaks among hospital patients and staff.

Since March 2020, the pandemic has continued to evolve. This snapshot from 2021 provides HHS and other decisionmakers with updated information on hospital perspectives. Specifically, this pulse survey offers hospital administrators' perspectives on the most significant strains that the response to COVID-19 has exerted on hospitals, as well as their perspectives on the longer-term implications of these strains.

Report in Brief continued

Limitations

The hospitals' front-line perspectives provide an important voice, among many, for HHS and other decisionmakers to consider as they grapple with the challenges presented or worsened by the pandemic. However, it is the perspective of hospital administrators at a point in time, February 22–26, 2021. OIG has not independently assessed the merits, costs, or effectiveness of the strategies or areas for government support identified by hospitals. As such, OIG is not endorsing the suggestions made by the hospital administrators.

Further, we recognize that HHS, Congress, and other government entities across the Federal, State, local, and Tribal levels are taking substantial actions on a continual basis to support hospitals in responding to COVID-19. For example, the recently passed American Rescue Plan Act of 2021 provides additional support and funding that could help to address some of the challenges that hospitals identified.

How OIG Did This Review

This report is based on a pulse survey conducted during February 22–26, 2021, with hospital administrators from 320 hospitals across 45 States, the District of Columbia, and Puerto Rico. Interviews focused on three key questions:

1. **What are your most difficult challenges in responding to the COVID-19 pandemic right now, and what strategies have you been using to address the challenges?**
2. **What are your organization's greatest concerns going forward?**
3. **How can government best support hospitals?**

Respondent hospitals included special pathogen centers, critical access hospitals, and a range of hospitals nationwide of various sizes and characteristics. We spoke with representatives from 320 hospitals that were part of our random sample of 397 hospitals, for an 81-percent rate of contact. (See Methodology on page 38 for additional information about how we conducted this pulse survey.)

HOSPITAL CHALLENGES: HIGHLIGHTS

Health Care Delivery

Meeting the Health Care Needs of COVID-19 Patients

Hospitals emphasized the significant clinical challenges in treating COVID-19 patients, some of whom are very ill, and patients with longer-term effects after recovering from acute illness. Hospitals also reported difficulty in balancing the care needed for COVID-19 patients with efforts to resume routine hospital care and challenges in discharging patients to post-acute settings during their recovery, which strained hospital capacity.

Delays in Care Resulting in Patients With More Serious Conditions

Hospitals reported that patients have delayed or forgone routine health care as a result of the COVID-19 pandemic, which has led to worsening of patient conditions. Administrators predicted that widespread delayed care could result in higher hospitalization rates and need for more complex hospital care in the future.

Increased Needs for Mental and Behavioral Health Care

Administrators voiced concern that the pandemic has led to greater mental and behavioral health needs among patients. Administrators anticipated that the needs for mental and behavioral health services at their hospitals would continue to grow and reported concern about meeting these needs.

Worsening of Longstanding Challenges at Rural Hospitals

Rural hospitals reported particular difficulty responding to the COVID-19 pandemic and that the pandemic had worsened longstanding challenges in staffing, limited capacity, and finances. Hospitals explained that strategies employed by other hospitals, such as sharing clinicians across systems and providing telehealth services, may not work for rural hospitals due to remote locations and lack of access to technology.

Concerns about Exacerbation of Health Care Disparities

Hospitals raised concerns that the COVID-19 pandemic has exacerbated existing disparities in access to care and health outcomes.

Benefits and Challenges of Expanded Telehealth Use

Hospitals reported that telehealth has become an important care delivery model during the COVID-19 pandemic. Administrators also reported some challenges in delivering care with telehealth. These challenges are that telehealth, by its very nature, cannot cover all aspects of health care delivery. They also reported that some patients, particularly those in underserved communities, do not have the devices or internet access to conduct video calls.

Staffing

Staff Burnout and Trauma

Hospitals reported that increased hours and responsibilities, along with other stressors caused by the COVID-19 pandemic, resulted in staff being exhausted, mentally fatigued, and sometimes experiencing possible post-traumatic stress disorder (PTSD). Several hospitals reported that witnessing COVID-19-related deaths especially weighed on staffs' mental health.

Staffing Shortages Due to High Turnover and Competition

Many hospitals reported that they were experiencing concerning staff shortages, particularly among nurses, raising concerns for hospitals about patient safety and quality of care. Hospitals also expressed concerns about the future of the health care workforce as the recruitment pool for nurses and other health care workers has continued to shrink.

Vaccinations

Diversion of Limited Resources to Vaccine Efforts

Although hospitals viewed their vaccination efforts as a positive step toward pandemic recovery, several hospitals noted that these efforts come at a cost—further stretching limited clinical staff and straining hospital finances. Hospitals reported that differences in government guidance on vaccine eligibility made it more complicated for them to determine who is eligible, requiring additional effort for hospitals.

Vaccine Hesitancy Among Hospital Staff and the Community

Some hospitals reported that some staff and members of the community were hesitant to take the COVID-19 vaccine or declined to get vaccinated due in part to safety concerns. Hospitals reported that some staff distrusted the rapid vaccine development and approval process and had concerns that the vaccines may not be effective or may pose risks.

Ensuring Vaccination Access for Rural and Other Underserved Populations

Hospitals reported that vaccinating rural communities presented unique challenges that made it difficult to ensure vaccination access for residents. Hospitals also reported needing to take extra steps to ensure access to vaccinations for some senior and low-income populations, such as those who do not have internet access or the technology skills to navigate online scheduling.

Finances

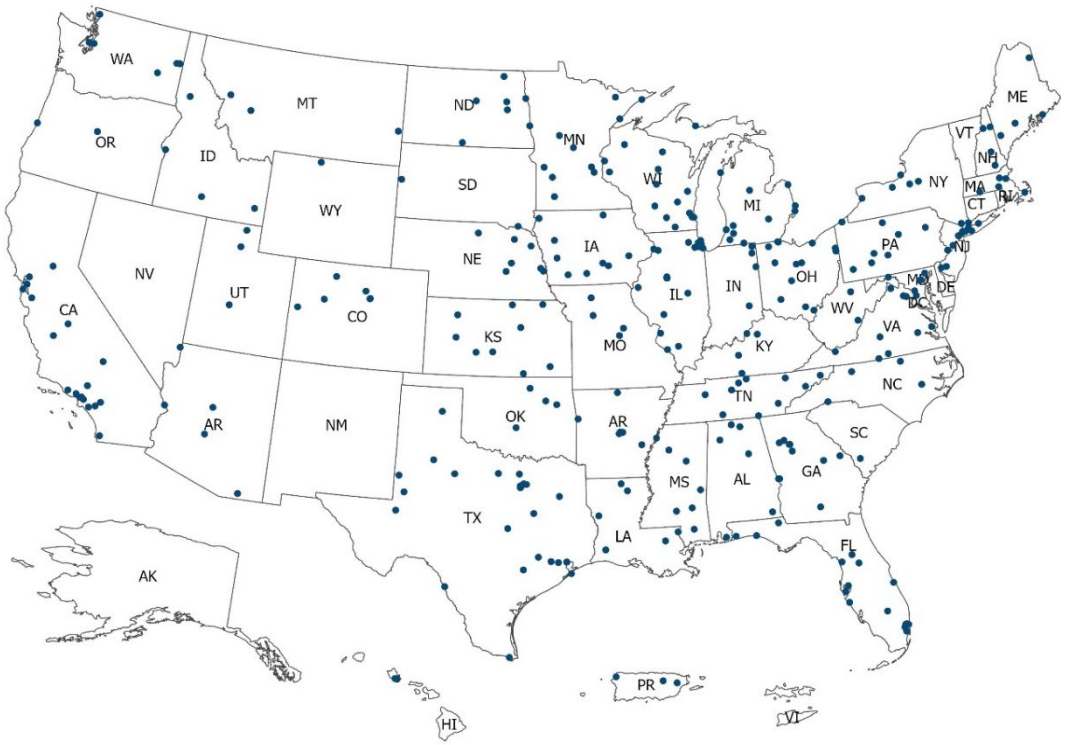
Financial Instability From Higher Costs and Lower Revenues

Many hospitals reported concerns about their financial stability as the COVID-19 pandemic had increased costs and decreased revenues. They explained that their higher costs were associated with patient care, staffing, PPE, and COVID-19 testing and vaccinations; lower revenues stemmed from fewer routine and elective services and reimbursement rates that, according to the hospitals, did not keep up with increasing costs of care for some COVID-19 patients.

TABLE OF CONTENTS

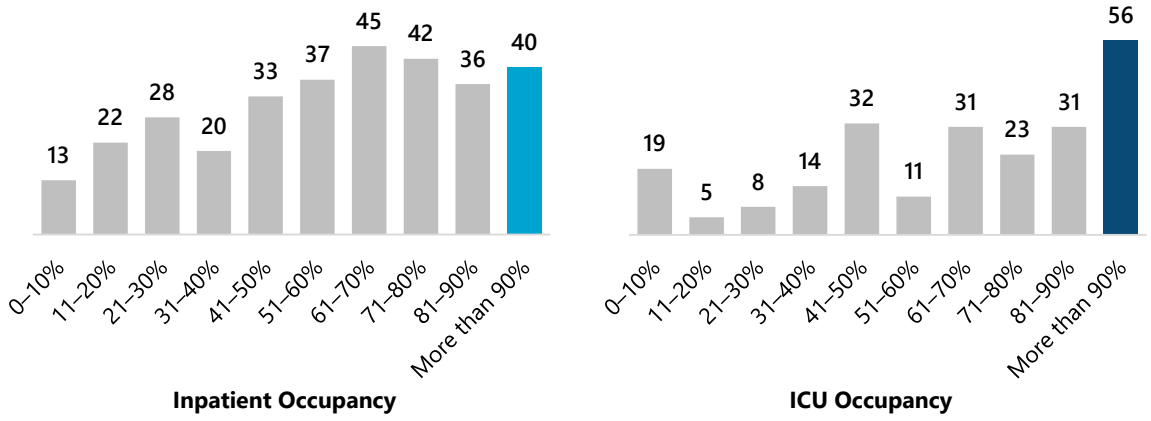
HOSPITAL LOCATION AND OCCUPANCY

Exhibit 1: The 320 responding hospitals were located in 45 States, the District of Columbia, and Puerto Rico.



Source: OIG analysis of 320 responding hospitals using the address listed for their provider number, March 2021.

Exhibit 2: Some responding hospitals were operating at an over 90-percent adult inpatient occupancy and/or an over 90-percent adult intensive care unit (ICU) occupancy.



Source: OIG analysis of HHS Protect data for February 17, 2021.

Note: For adult inpatient occupancy, the total equals 316 responding hospitals because not all hospitals reported data in HHS Protect. For adult ICU occupancy, the total equals 230 because we excluded 86 hospitals that reported not having any ICU beds.

FINDINGS

HEALTH CARE DELIVERY

Hospitals reported significant challenges in meeting the needs of COVID-19 patients and uncertainty about future COVID-19 caseloads

Hospitals are at the forefront of health care delivery during the COVID-19 pandemic, and hospital administrators described the strain the pandemic has placed on patient care. In some cases, hospitals reported that underlying problems with health care delivery were exacerbated, such as challenges providing care for underserved patients and challenges for rural hospitals with limited resources.

The volume of COVID-19 patients and the complexity of their immediate and long-term needs significantly strained patient care and hospital operations

Hospitals reported being overwhelmed by the volume of patients, especially during surges in COVID-19 infections. They explained that this put a severe strain on their bed capacity. Some hospitals reported that they operated at over 100-percent capacity during surges, and high occupancy continues for some hospitals. At the time of our survey, 40 responding hospitals had over 90-percent inpatient occupancy and 56 had over 90 percent of their ICU beds occupied. (See the Appendix on page 41 for more information about the capacity and other characteristics of responding hospitals.) One urban hospital, with a nearly full ICU the week before our survey, reported that it would do only urgent surgeries and discharged patients to their homes for recovery because of a shortage of recovery areas in the hospital.

Hospitals emphasized the great clinical challenges in treating COVID-19 patients, particularly those with severe illness and comorbidities. Hospital clinicians have had to keep up with emerging treatment protocols, often without sufficient specialty staff, such as infectious disease specialists, pulmonologists, respiratory therapists, and clinical nurses trained in treating COVID-19.

COVID-19 patients with longer-term effects will also need complex specialty care. Hospitals reported seeing patients with serious post-COVID conditions, such as pulmonary issues, pneumonia, heart problems, and blood clots. One hospital described "a tsunami of people going forward" who they predicted would experience long-term effects from COVID-19.

Administrators reported challenges in balancing the complex and resource-intensive care needed for COVID-19 patients with efforts to resume routine hospital care. Hospitals reported having difficulty integrating COVID-19 care into normal operations, chiefly because of concerns about infection control. As hospitals reopened more services for patients after the early months of the pandemic, such as resuming elective surgeries, they experienced increased challenges in keeping infected COVID-19 patients separated from non-infected patients. Complicating this further, hospitals explained that a new patient's COVID-19 positivity status may not be immediately known.

Hospitals reported challenges in discharging COVID-19 patients during their recovery, which affected available bed space throughout the hospital

Hospitals reported difficulty in discharging COVID-19 patients following the acute stage of their illness, resulting in longer hospital stays. Administrators reported challenges in transferring patients to post-acute facilities such as nursing homes, rehabilitation hospitals, and hospice facilities. According to administrators, some post-acute facilities were either unwilling or unable to accept patients because the facilities were concerned about potential COVID-19 infections. Others did not have bed capacity or staff to care for the patients.

> **"We have patients in the acute-care setting that really do not belong here in terms of what they need clinically but can't move on because there is not an available option."**
>
> **- Hospital administrator**

Administrators reported that delays in discharge affected available bed space throughout the hospital and had other downstream effects. For example, hospitals reported that patient opportunities for specialized post-acute care (e.g., rehabilitation) were delayed. Hospitals also reported that longer stays created bottlenecks throughout hospitals, including in ICUs and emergency departments. As an example, one hospital reported that 13 of its 17 emergency treatment rooms were occupied by COVID-19 patients waiting to be admitted to the hospital.

Uncertainty about future COVID-19 caseloads and the implications of new virus variants adds to hospitals' challenges

Administrators expressed concern about emerging issues such as new variants of the virus and vaccine efficacy. Hospitals worried that the new variants could bring additional challenges and changes to treatment needs, infection control, and best care practices. Administrators also had questions about the long-term efficacy of vaccines and worried about the possibility of future COVID-19 surges. One hospital administrator asked, "Are we out of the woods or will it come back again?" Another

hospital expressed concern that COVID-19 may become a regular seasonal infection, like influenza, which could present serious ongoing preparedness challenges given that COVID-19 is both more infectious and more deadly than the flu.[1]

> **"We are going to have to learn to live with COVID; COVID is not going away."**
>
> **- Hospital administrator**

Hospitals reported that continuing fluctuations in the number of patients with COVID-19 made it difficult to plan for the future. Hospitals were cautious about taking steps toward resuming normal operations. For example, one hospital not treating any COVID-19 patients the week before our survey reported that it was hesitant to repurpose its antibody infusion room or to fill rooms designated for isolation because of the risk of another wave of COVID-19 cases, despite other demands for this space.

Hospitals reported that the pandemic led to delayed care and feared that an erosion of trust in hospital safety would continue to keep patients from seeking needed care

Administrators raised concerns about the public not receiving needed health care during the pandemic due to patients delaying and forgoing care, as well as to hospitals suspending elective care due to COVID-19. They reported that lack of care and reduced use of hospitals have had significant ramifications for patients and the hospitals that treat them.

Hospitals reported that patients have delayed or forgone routine health care, which has led to worsening of patient conditions

Many hospitals chose, or were required, to suspend elective surgeries and other services at different points during the pandemic to preserve resources for emergencies and COVID-19 surges, but according to administrators, delayed care has persisted past these early suspensions. As causes of delaying and forgoing care, administrators cited patients' fear of contracting COVID-19 and practical concerns such as difficulty finding transportation during the pandemic. Hospitals described reduced patient volume across hospital departments and services, including emergency care, preventative care, chronic condition management, and surgeries. Delayed care included preventative and urgent care for serious conditions such as

heart attacks or strokes. One administrator attributed some emergency room deaths at their hospital to patients not following up on their prior care needs.

> **"Things that are elective, if not dealt with over time, are no longer elective."**
>
> **- Emergency preparedness director**

Administrators predicted that such widespread delayed care would result in higher hospitalization rates and a need for more complex hospital care in the future. They explained that when patients miss routine exams and diagnostic tests, such as cancer screenings and cardiology tests, serious diagnoses may go unidentified. One administrator reported finding a sharp decline in cancer diagnoses during the pandemic, and that patients were not presenting for examination at the onset of symptoms. Another administrator described seeing patients for diabetes and cardiac management who were sicker and required more care after postponing prior appointments. One administrator reported, "My only concern is how sick our patients are. There was a long period of time where patients were not receiving primary care. We see the impact here almost daily with the symptoms patients are presenting with."

Hospitals reported that public trust in hospital safety and credibility has eroded during the pandemic

Hospital administrators perceived that some in their communities appeared to newly question whether hospitals are safe and can keep patients safe. Administrators reported that patients continue to be concerned about contracting COVID-19 in the hospital despite the protective procedures that hospitals have put in place to mitigate exposure. Some administrators speculated that this could be in part because of confusion over evolving public health guidelines during the pandemic.

Hospitals voiced concern that some patients were less likely to trust hospital care recommendations as credible, possibly because the patients received confusing and changing messages about COVID-19 during the pandemic. Administrators worried that lack of trust could contribute to patients further delaying and forgoing care. One administrator said, "Unless we can get everyone on the same page to get routine health care, we shudder at the burden of disease that may occur."

> **"My concern is with our health care image in the community. There are people who have lost trust in our health care system. Our concern is about re-establishing trust among the community."**
>
> **- Hospital CEO**

Hospitals expressed concern about meeting the increased need for mental and behavioral health care that has emerged as an outgrowth of the pandemic

Administrators voiced concern that the pandemic has led to greater mental and behavioral health needs among patients. They explained that these added needs resulted from many factors, including lockdowns, social isolation, and burnout. Administrators anticipated that the needs for mental and behavioral health services at their hospitals would continue to grow. Administrators reported concern about meeting these needs, and about how mental health challenges can exacerbate other health problems. One hospital reported concern for seniors in particular, observing that the elderly may be among the most vulnerable to depression associated with the pandemic.

> **"In this pandemic, we talk about the death toll…but the morbidity that we are overlooking is mental health."**
>
> **-Administrator of two hospitals within a network**

Some hospitals believe that they may not have the capacity or resources to meet the increased needs for mental and behavioral health care. For example, one hospital closed a psychiatric unit that focused on elderly patients because it needed the unit's staff to help serve COVID-19 patients. In addition to inpatient care, hospitals often serve as a primary mental health provider in communities. Some administrators explained that their role includes conducting mental health screenings and treating mental and behavioral health issues as comorbidities to other medical conditions. Hospitals reported that there was a need for additional resources and specialists to provide this care before the pandemic, and that the pandemic increased the need further. Additionally, administrators reported that it can be more difficult to treat COVID-19 patients who suffer from mental illness or behavioral challenges.

Rural hospitals reported that longstanding operational challenges have worsened during the pandemic

Administrators reported that the COVID-19 pandemic has disproportionately hampered operations for rural hospitals. For example, they reported that the pandemic has worsened longstanding challenges in recruiting and retaining staff, limited bed capacity, lack of access to specialized services, and financial strain.

Some hospitals raised that strategies used by other hospitals to address resource challenges, such as sharing clinicians across systems, may not work for rural hospitals. One administrator reported that rural hospitals do not have access to back-up resources, observing, "As a rural community, we have a limited number of physicians. If one physician falls ill, we're done." A few rural hospitals reported attempts to provide more telehealth services to fill gaps in care, but their patients sometimes lacked access to the technology needed to use these services. They also reported that limited patient access to technology, such as broadband internet access, affected other aspects of care, such as hampering outreach about vaccines.

> **"We are essential…If we were not here, I don't know where these patients would have gone."**
>
> **-Administrator, rural hospital**

Further, administrators reported that a lack of available beds at many larger hospitals sometimes prevented them from transferring COVID-19 patients and other critically ill patients. Most rural hospitals are designed to provide urgent and routine care services for a wide geographic area and to transfer patients requiring specialty or intensive care to other hospitals. One rural hospital in Louisiana that does not have an ICU reported that it was contacting hospitals in neighboring States because they had the closest available ICU beds. Among our responding hospitals, 67 served rural communities and 28 of these hospitals operated fewer than 15 inpatient beds. (See the Appendix on page 41 for information on the communities served by the responding hospitals.)

Hospital administrators raised concerns that the COVID-19 pandemic has worsened existing disparities in access to care and health outcomes

Hospitals reported that the COVID-19 pandemic has exacerbated longstanding problems with access to care, particularly for rural communities and for low-income populations across geographic settings. Hospitals reported that many rural communities face health care provider shortages, transportation challenges that make it difficult to access hospitals that may be hours away, and lack of internet service to support using telehealth to reduce these barriers. Many low-income individuals face barriers to health care (even in non-rural settings), including lack of health insurance or transportation.[2] Hospitals also reported that low-income individuals may be unable to afford internet service or devices to support using telehealth to reduce these barriers.

In addition, hospitals raised concerns about disparities in health outcomes, including higher incidence rates and severity of COVID-19 infections in certain communities, concerns raised by the others in the health care community throughout the pandemic. According to the Centers for Disease Control and Prevention (CDC),

communities that have high levels of poverty, crowded housing, and other attributes associated with higher social vulnerability have been more likely to experience high rates of COVID-19.[3] Among responding hospitals, 41 were located in counties where 20 percent or more of the population had household incomes below the Federal poverty level, and 113 hospitals serve communities with higher social vulnerability than the national average according to CDC's Social Vulnerability Index. (See the Appendix on page 41 for information on the communities served by the responding hospitals.)

Administrators from hospitals in communities with higher social vulnerability reported deep concern about worse outcomes for many of their patients. Hospitals also reported clinical challenges in treating patients with certain comorbidities that disproportionately affect people of color, such as heart and lung ailments and chronic illnesses such as diabetes, and that patients with these comorbidities are at higher risk of severe illness from COVID-19.[4] These patients may enter hospitals at a more severe stage of illness, and require a higher level of care. In some cases, hospitals explained that they lack this advanced care capacity or may lack the resources to treat a large number of vulnerable patients. Hospitals reported that patients who have low incomes are also less likely to have access to primary care that could prevent disease worsening.

Hospitals reported the adoption and use of telehealth was beneficial and a change they want to retain despite some challenges

Administrators reported that telehealth has become an important care delivery modality for their hospitals during the COVID-19 pandemic, increasing patient access to care while reducing risk and workload for hospital staff. Hospitals described a wide range of situations for which they implemented or expanded telehealth services, including connecting remote specialists to help severely ill patients in ICUs, conducting followup visits for patients recovering from COVID-19, conducting mental health services, and providing education for at-home care.

> **"The pandemic created a crisis for us to adopt this [telehealth] technology."**
>
> **- Hospital CEO**

Although administrators were overwhelmingly positive about the benefits of telehealth, they reported three key challenges in delivering care with this method. First, telehealth cannot cover all aspects of health care delivery and by its very nature lacks the in-person interaction valued by some providers and patients. Second, technology created challenges for telehealth care delivery. Hospitals reported that some patients do not have the devices or internet access to conduct telehealth visits, particularly in underserved communities. One administrator worried that telehealth

visits do not work equally well for all communities. Although some patients are able to conduct video calls, others must rely on audio-only telephone calls, particularly the elderly and those in underserved communities. Third, some hospitals reported that they received lower payments for some services provided through telehealth than they would have received for in-person services, and they did not believe the payments reflected the value of those telehealth services.

STAFFING

Hospitals reported that increased workloads and the stress of treating seriously ill and dying COVID-19 patients have led to staff burnout and, in some cases, trauma

Hospitals reported that increased hours and responsibilities, and other stressors caused by the COVID-19 pandemic, resulted in staff being exhausted, mentally fatigued, and sometimes experiencing possible PTSD. Hospitals reported that for the past year, staff have worked longer hours, extra shifts, and mandatory overtime. In addition, some reported that caring for higher level and critically ill patients who might have been transferred to other facilities prior to the pandemic caused additional stress on staff who felt ill-equipped to handle such care on a continuing basis. Further, hospitals reported that staff were "wearing many hats"—balancing multiple clinical and administrative responsibilities to cover the staffing gaps. Other staff were pulled away from their normal duties to complete new COVID-19-related tasks. For example, hospitals reported dedicating staff to meet COVID-19 data entry and reporting requirements, with one administrator describing it as "very labor intensive." Another hospital reported pulling staff from their regular duties to manage the thousands of incoming telephone calls when the community learned that the hospital had received vaccine doses.

Several hospitals reported that the COVID-19-related deaths that staff witnessed especially weighed on their mental health. One administrator observed that, with family unable to be present at patient bedsides, it has been heartbreaking for nurses to be the last person a dying patient sees. Further, administrators reported that hospital staff experienced COVID-19 deaths among their coworkers, which took a toll on those remaining and continuing the work. One representative from a hospital network described a monthly gathering for staff to mourn colleagues who passed

"Long-term solutions for staff fatigue, compassion fatigue, and possible PTSD will need to be identified so that we can help our staff be able to care for themselves, their families, and our patients."

-Director of Nursing, hospital at 100% ICU occupancy

away from COVID-19. Adding to this emotional distress, hospitals explained that some staff have had to separate from their families for extended periods to protect their family members from infection.

Administrators at one major teaching hospital (where, the week before our survey, nearly 50 percent of ICU patients had COVID-19) reported that treating COVID-19 formerly involved everyone on staff but now involves only certain staff while others get to go back to "normal." The administrators explained that staff still treating COVID-19 patients experienced more fatigue attributable to loss of the teamwork that existed in earlier months of the pandemic, and a strong desire to return to normalcy like some of their colleagues.

Hospitals reported that high turnover and competition for medical staff have created staffing shortages that in some cases affect patient care

Hospitals reported that they were experiencing higher than normal turnover among medical staff, resulting in concerning staffing shortages. Among our responding hospitals, 38 reported to HHS Protect that they faced a critical staffing shortage during the week before our pulse survey. Turnover was particularly high among nurses, according to the hospitals. One hospital in a high-poverty and socially vulnerable community in Texas (which was operating at 100-percent ICU occupancy the week before our survey) reported that its annual average for nurse turnover increased from 2 percent prior to the pandemic to 20 percent in 2020. Hospitals also reported losing other types of staff in the past year, including respiratory therapists, certified nursing assistants, phlebotomists, laboratory technicians, and other support staff vital to hospital operations.

Many hospitals attributed the increased turnover of staff to stress and burnout caused by COVID-19, leading some staff to retire early or seek jobs outside of health care. Hospitals also cited competition for health care workers and the opportunity to earn more money by leaving a hospital to join a staffing agency.

Some hospitals reported struggling with the unexpected increase in competition for medical staff

Administrators reported an increase in competition for medical staff, particularly nurses, among hospitals and staffing agencies. Many hospitals reported that they were unable to compete with staffing agency salaries, with one administrator describing the competition over health care workers as a "wage war." Hospitals that lost nurses reported that they often experienced increased staffing costs from the higher hourly rates charged by staffing agencies.

> **"The cost [for agency nurses] has gone from $60–$70 to $200 per hour now. To get them in here to help has become an impossibility."**
>
> **- CEO, hospital that reported critical staffing shortages**

Smaller hospitals and rural hospitals reported that it was particularly hard for them to compete for staff with large urban hospitals, and that the inability to compete led to further shortages. An administrator from a critical access hospital stated that they always had a few nursing vacancies that they could not fill, even with offering bonuses. As another administrator explained, recruiting providers in a rural community is always difficult, but had gotten harder during the pandemic.

Hospitals reported that staffing shortages posed challenges in maintaining patient safety and quality of care

Hospitals raised concerns that the quality of care has suffered as a result of losing nursing staff. Several administrators reported that staffing shortages have forced them to assign substantially more patients per staff, such as one administrator who reported that their hospital had to cut its staff-to-patient ratio in half for some periods during the pandemic, to 1-to-12 from 1-to-6. Reduced staff-to-patient ratios can lead to mistakes when less attention is given to each patient. Hospitals also reported that staffing shortages have resulted in staff having to work longer hours, extra shifts, and mandatory overtime for the past year. Representatives from one hospital network reported that it had seen an increase in central line infections, which can be life-threatening. They attributed the increase in these infections to not having sufficient staff and reported that staff's fatigue led to process failures. Another hospital reported that feedback scores from patients on communication and quality had decreased and attributed that to tired and frustrated staff.

Some hospital administrators reported quality of care concerns even when they bolstered staffing levels with traveling nurses, reporting that these nurses are not as familiar with the hospital's particular processes as nurses with longer tenures. For example, one hospital attributed a rise in its hospital-acquired infections to the hiring of agency staff not trained in that hospital's infection control processes.

Hospitals expressed concerns that a shrinking recruitment pool for nurses could continue to worsen staffing shortages

Hospitals raised concerns that nationwide shortages of nurses and other health care workers, already a concern before the COVID-19 pandemic, had worsened as a result of the pandemic. Administrators from several hospitals believed that the pandemic has deterred people from entering the medical profession, with fewer students seeking degrees in medical disciplines. As one hospital administrator said, "We can't overstate the staffing gap that exists now that's likely to get worse over the next few years." An administrator from one teaching hospital reported that the hospital would typically recruit nurses who have completed training at the hospital, but this year only 100 nurses were expected to graduate and the hospital had 200 open nursing positions.

> **"This [pandemic] has really burnt out the health care industry… I am concerned about what we are going to do about making people want to go into health care as a profession."**
>
> **- Hospital president**

Further, several hospitals expressed concern that, because of the pandemic, newly graduated nurses may not have gained sufficient clinical experience with other ailments, and that hospitals lacked resources to adequately train new nurses. One administrator explained that some nursing students have been unable to graduate because they could not complete their clinical training.

VACCINATIONS

Hospitals reported that vaccination efforts were positive steps toward pandemic recovery but exacerbated challenges with clinical staff shortages and hospital finances

Hospital staff were among the earliest to get vaccinations, which helped to reduce risk of infection to front-line health care workers and to limit the spread of COVID-19 within the hospital. Hospitals reported that they have set up the infrastructure necessary to administer COVID-19 vaccines to their communities. These efforts include creating mass vaccination sites and reallocating clinical staff to administer vaccines.

Many hospitals reported that they were ready to vaccinate on a large scale as soon as vaccine supply became more available. As one administrator explained, hospitals are well positioned to administer vaccines, given that they have the needed space, exam rooms, clinical expertise, and workflow processes. Hospitals viewed their vaccination

efforts as a positive step toward pandemic recovery. For example, one hospital noted that providing vaccinations was important to economic recovery.

> **"What the public doesn't see is that the same health care workers they rely on to provide care are the same ones being pulled to distribute vaccinations. They can't be everywhere at once."**
>
> **- Emergency manager**

Some hospitals reported that vaccination efforts sometimes exacerbated existing challenges with clinical staff shortages and hospital finances. Some hospitals reported needing to divert clinical staff away from patient care to administer vaccines, which has "strained an already stressed system" as one administrator explained. Hospitals reported shifting nurses from other departments, including ICUs, operating rooms, emergency departments, and obstetrics, to administer vaccines, and sometimes at remote locations.

Hospitals reported that it takes a considerable amount of staff time to operate vaccination clinics. One administrator explained that it took 25 staff members working an 8-hour shift to distribute 600 vaccines. Hospitals also reported frustration with inefficiencies in required data reporting. For example, one hospital reported that to meet Federal, State, and local reporting requirements, it had to enter vaccine data into three separate systems. It characterized such data entry as "cumbersome" and "redundant," noting that "none of the three systems are talking to each other, [despite the fact that] they are inputting the exact same data into each system."

> **"[Vaccination] is an immense resource and we're happy to contribute because it decreases the rates of COVID, but it is significant the resource[s] that [go] into that."**
>
> **- Hospital president**

Hospitals also reported that costs associated with vaccine administration have strained hospital financial resources. Beyond staffing, hospitals explained that costs include equipment for storing vaccines (e.g., freezers) and supplies to administer vaccines. Although a few hospitals reported using the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to offset the expense of vaccinating the community, others reported that this support did not cover all of the hospital expenses for operating vaccination sites.[5] (Note that after our pulse survey, CMS increased the Medicare payment amount for administering the COVID-19 vaccine to offset costs associated with establishing or operating vaccination sites and hiring additional staff.)[6]

Differences in government guidelines regarding vaccine eligibility and prioritization created challenges for hospitals

Hospitals reported receiving varying information from different levels of government about who is eligible to receive the COVID-19 vaccine and when they are eligible. Federal, State, and local governments have prioritized different population groups to receive vaccines. CDC's Advisory Committee on Immunization Practices made recommendations that prioritized health care workers and long-term care facility residents, but States have discretion to adjust the guidelines based on their populations, vaccine supply, and capacity to vaccinate.[7]

Hospitals reported that differences in vaccination priorities across jurisdictions have made it more complicated to determine who is eligible, which can be time-consuming and resource-intensive for hospitals. For example, hospitals serving communities at State borders must vary their vaccination approach based on each State's priorities. One hospital explained, "We're near Indiana and Michigan, and depending on what side of [the] street you're on, it affects what rules apply." A further complication is that within States, counties and cities may determine their own priority populations that can vary across each jurisdiction. For example, one hospital network noted that "vaccine 1b eligibility criteria and allocation varies to a great extent across Illinois, Wisconsin, Cook County, and City of Chicago."

Hospitals reported that some hospital staff and members of the community were hesitant to get vaccinated

Hospitals noted that they were struggling to convince some staff of the importance and safety of the vaccine. Administrators from several hospitals reported more than a third of their staff had declined to be vaccinated as of the date of our survey. Administrators attributed this lack of willingness to take the COVID-19 vaccine to multiple causes. For example, they explained that some staff distrusted the rapid vaccine development and approval process and others had concerns that the vaccines may not be effective.

Hospitals also raised concerns about hesitancy among members of their communities and reported working to combat misinformation about the vaccine. Hospitals worried that fewer vaccinations would allow the virus to continue circulating longer than necessary. Some administrators reported that the public lacked complete information about vaccines, which appeared to increase hesitancy to be vaccinated. For example, one administrator reported hearing a variety of concerns, from questions about the long-term side effects of the vaccines to false assertions that vaccines carry microchips.

Hospitals reported challenges in ensuring access to vaccinations for rural, senior, and low-income populations

Administrators reported that vaccinating rural communities presented unique challenges in ensuring access. Hospitals in rural areas, including critical access hospitals, reported that rural areas often have few vaccination sites and lengthy travel between sites. For example, in some rural communities, the hospital may be the nearest vaccination site for patients who live hours away. Hospitals noted that this distance can make it difficult to vaccinate residents who do not have reliable transportation. Officials from one critical access hospital noted that many rural areas have a higher proportion of low-income residents, who may not have reliable transportation for long travel. Additionally, hospitals explained that those without a car have difficulty traveling to mass vaccination sites.

> **"We feel it's important to do more than stand up a vaccination site. We provide education and access. Part of that access strategy is to go out to people."**
>
> **- Hospital president**

Hospitals reported taking extra steps to ensure that senior and low-income populations could access vaccinations. Vaccination appointments have been commonly scheduled online, and hospitals reported that this creates barriers for individuals who lack internet service, devices, or capabilities needed to access and navigate online scheduling. For these patients, hospitals reported needing to use different scheduling options, such as calling elderly patients directly to schedule vaccination appointments. Some hospitals also reported going into the community to vaccinate, such as by setting up vaccine clinics in parking lots in certain neighborhoods.

Hospitals reported frustration with the unpredictable and insufficient supply of vaccines

Hospitals reported that the supply of vaccines they receive has been unpredictable, and they often get little advance notice about changes to shipment quantities. Administrators explained that quantities of vaccine shipped to hospitals varied from week to week and did not always match the amount they expected. Hospitals reported that this inconsistency led to inefficient use of resources and caused hospitals to cancel patient appointments at the last minute.

> **"There is far more capacity to vaccinate than there [are] available vaccine doses."**
>
> **- Emergency management director**

Several administrators expressed frustration about building infrastructure and planning for mass vaccinations only to have that capacity be underutilized due to inconsistent supply. For example, one hospital reported that it has capacity to vaccinate 5,000 people a week but received only 2,000 doses a week. Another hospital reported creating three vaccine locations within its system and allocated staff to provide 6,000–8,000 vaccines a week but had no vaccines at the time of their survey on February 21, 2021. (Note: Since the time of the pulse survey conducted the week of February 22–26, 2021, the Food and Drug Administration (FDA) issued an emergency use authorization for a third vaccine for the prevention of COVID-19, helping to lead to an increase in daily vaccinations.)[8, 9]

SUPPLIES

Hospitals reported difficulty maintaining a steady supply of affordable, high-quality PPE

Hospitals reported that they were no longer experiencing the extreme shortages of PPE that occurred at the beginning of the COVID-19 pandemic, but some still lacked dependable supply chains for PPE. Hospitals noted that supplies of surgical gloves and N95 masks were particularly unpredictable. One problem reported with gloves was that only large sizes could be purchased, often the wrong size for many hospital staff. During the week before the pulse survey, 19 of our responding hospitals reported to HHS Protect that they could not order and obtain N95 masks. Further, some hospitals reported sanitizing and reusing PPE to preserve supplies.

> **"We have been reusing masks and supplies, per CDC guidelines, in an effort to extend the life of the supplies and reduce costs."**
>
> **-Compliance officer**

Many hospitals reported difficulty in identifying reputable vendors to provide a consistent supply of PPE. As one administrator described, "We are routinely changing vendors because we can't get [PPE] from our normal manufacturers and vendors." Some administrators expressed that it was inefficient for individual hospitals to be searching for vendors and that there should be more centralized supply chain management.

When hospitals must switch to N95 masks produced by different manufacturers, staff often must repeat mask fit-testing, which one administrator reported occurred for their hospital four or five times. Even when hospitals found PPE vendors, administrators reported inconsistent delivery, including orders that were cancelled, delayed, or incorrect. One hospital noted that it was difficult to anticipate when their orders would be backordered or cancelled. This made it challenging to build up supplies, and hospitals reported concerns about having enough PPE supplies for surges or waves of COVID-19 infections in the future.

> **"Hospitals our size with 300 beds looking for N95s was not an efficient use of our time."**
>
> **- Hospital president**

Some hospitals reported receiving poor-quality PPE and others reported inflated prices. For example, one hospital reported that when they purchased PPE made outside the United States, many of the supplies did not meet U.S. standards. A few hospitals described the PPE that they received as "counterfeit" or discovered the PPE was inadequate for use after testing it. Some hospitals also indicated that they experienced substantial price increases for PPE. One administrator said, "We used to pay about $1 per [N95] mask. Now it's $8 to $9 per mask."

FINANCES

Hospitals reported that their operational costs have risen dramatically while their revenues have declined, threatening their financial stability

Many hospitals identified financial stability as a concern resulting from the COVID-19 pandemic. Administrators pointed to a variety of increased costs that their hospitals encountered during the pandemic, including higher costs associated with staffing and PPE, as well as COVID-19 patient care, testing, and vaccinations. Some hospitals also reported increased administrative costs associated with new data reporting requirements for COVID-19 cases, testing, and vaccinations. Some hospitals expressed that the combination of their higher costs coupled with declining revenues raised concerns about whether they would be able to remain in operation.

Hospitals that serve disproportionately under- and uninsured populations and rural communities reported being particularly concerned about financial instability. These hospitals also tend to serve more patients enrolled in Medicaid, which often reimburses at lower rates than private insurance. Several hospitals noted that they faced financial challenges prior to the pandemic and worried that it would be hard to recover financial stability after the pandemic ends. As an administrator of a hospital serving a community with high poverty rates described, "We were one of the [hospitals in] danger of disappearing…now we have to restart in a different world, and I don't know if we can get it back."

> **"Labor costs, supply costs, utility costs, insurance costs have all gone up. Everything on the expense side has gone up and the revenue side has not kept pace."**
>
> **- CEO, rural hospital**

Hospitals reported a significant decline in revenue resulting from suspending elective procedures. In March 2020, the Centers for Medicare & Medicaid Services (CMS) recommended the suspension of elective surgeries and other procedures to help conserve PPE and other supplies needed to respond to the pandemic.[10] The next month, in April 2020, CMS issued additional recommendations to guide practices as State, Tribal, and local health care entities considered safely resuming elective surgeries and other procedures.[11] However, hospitals reported that non-COVID-19-related services have remained low, with fewer patient visits for both routine and emergency care and fewer elective procedures (compared to before the pandemic). As a result of fewer patient visits, one administrator said their hospital was operating at a 25-percent reduction in revenue. As discussed earlier in the report, hospitals surmised that fear of contracting COVID-19 was a main cause of patients avoiding coming to the hospital, even for medically necessary treatment.

Some administrators expressed that, based on their experience, Medicare fee-for-service reimbursement did not always cover their costs associated with some COVID-19 patients. For example, one hospital estimated that it was potentially losing $3,000 per COVID-19 patient. Medicare reimburses hospitals a predetermined amount based on the COVID-19 diagnosis and any other diagnoses for the patient, and provides additional payment increases to hospitals as part of the CARES Act.[12, 13] However, administrators believed that these reimbursement amounts often did not cover their added staff and equipment costs associated with COVID-19 patients who have prolonged ICU hospital stays.

Medicare alternative payment models that base payment on value, risk, and outcomes presented a different set of financial challenges, according to hospital administrators. Although one administrator expressed satisfaction with payments under such models, other hospitals noted concerns that they could be penalized under alternative payment models, specifically in calculations of future incentive payments. For example, one hospital worried that caring for COVID-19 patients, who often have lengthy hospital stays and increased risk of hospital-acquired infections, could

negatively affect their quality metrics, potentially costing "hundreds of thousands of dollars" in missed incentive payments.[14]

Hospitals expressed uncertainty about rules on repayment of prior Federal loans

Several administrators expressed concern about whether they would have to repay the Federal financial assistance that they had already received. Hospitals noted that loans from the Medicare Accelerated and Advance Payment Programs were essential in facing cash flow disruptions during the early days of the pandemic. However, they anticipated problems repaying the loans when the first payments become due starting late March 2021.[15] Some hospitals also said that guidance on CARES Act funds, such as Paycheck Protection Program (PPP) loans, seemed to have changed over time, leaving them uncertain about the current rules for repayment.

ADDRESSING HOSPITAL CHALLENGES

Hospitals reported implementing strategies to address challenges and described areas in which new and continued government support would be helpful

Hospitals described a range of strategies that they used to address the challenges arising from the COVID-19 pandemic. For example, to ensure that they could meet the needs of COVID-19 patients, hospitals reported bringing in expert consultants to share best practices for standards of care. To combat staffing shortages, hospitals reported reallocating staff from other departments and offering higher pay and bonuses to recruit and retain staff. In addition, to ensure the success of vaccination efforts, hospitals reported leveraging community resources and educating the public on the safety and importance of getting vaccinated. (See the Selected Hospital Strategies section on page 26 for more detail on some of the strategies that hospitals reported.) Hospitals expressed appreciation for the financial support and regulatory flexibilities that the government has extended to hospitals and noted that the assistance has been critical to their continued operations.

Hospitals also described areas in which new and continued types of government support would be helpful in responding to, and recovering from, the COVID-19 pandemic. The hospitals' front-line perspectives provide an important voice, among many, for HHS and other decisionmakers to consider as they grapple with the challenges presented or worsened by the pandemic. However, OIG has not independently assessed the merits, costs, or effectiveness of the areas for government support identified by hospitals, and as such, OIG is not endorsing them. Rather, these ideas are presented to provide information for decisionmakers. Some challenges identified by hospitals may not be within HHS's authority to address or may require legislation.

Further, we recognize that Congress, HHS, and its partners across government have already taken and continue to take action to alleviate hospital challenges. The hospital perspectives reflect a specific point in time—February 22–26, 2021. Since then, the American Rescue Plan Act of 2021 was signed into law on March 11, 2021, and provides HHS with additional funding to combat and respond to the COVID-19 pandemic, including programs that support hospitals.[16] Further information about the American Rescue Plan Act can be found in the Background on page 31.

Enhancing knowledge and guidance on the prevention and treatment of COVID-19

Hospitals described opportunities for government support to help them treat patients with and without COVID-19. These included additional guidance on testing, treatment, and infection control that is consistent across government entities and is up-to-date with scientific understanding of the virus.

Hospitals indicated that it would be helpful for government to:

- Update recommendations for screening (e.g., temperature checks), testing, and quarantine procedures to accommodate ongoing developments. For example, how recommendations should be applied to people who are vaccinated.
- Provide additional clinical research and education efforts regarding the long-term health care impacts and service needs associated with post-acute COVID-19 care. The hospitals indicated that this should include clear guidance for patients recovering from COVID-19 who may have long-term complications.
- Provide public health updates to keep hospitals and the public informed on emerging variants and up-to-date clinical guidance on how to treat them.

Providing support to increase care to underserved communities

Hospitals described existing disparities in health care access and outcomes for underserved communities that COVID-19 has worsened.

Hospitals indicated that it would be helpful for government to:

- Address health care disparities and support hospitals' efforts to serve underserved communities, such as with funding and continuing Federal programs.
- Promote the use of telehealth for specialty services, such as pulmonology and intensive care, and sponsor infrastructure improvements to support expanded access to telehealth.
- Consider making policies in the public health emergency waivers permanent after the emergency declaration ends to take advantage of new forms of service delivery, for example, telehealth waivers that allow visits to originate in patients' homes, and the waiver allowing out-of-State practitioners to provide services in a State in which they are not licensed.[17]

Addressing hospital staffing needs and helping to support current staff

Hospitals described critical current staffing shortages, particularly among nursing staff, as well as burnout and trauma among staff from the COVID-19 pandemic.

Hospitals indicated that it would be helpful for government to:

- Assist hospitals in acquiring additional staff during emergency situations, including the vaccination effort. As one example of this type of program, one hospital noted that using the National Disaster Medical System helped some hospitals in rural areas with additional emergency personnel.
- Assist hospitals, especially rural hospitals, in recruiting professional health care staff. For example, the government could increase the Small Rural Hospital Improvement Grant Program, expand incentives for the National Health Service Corps to work in rural settings, and provide additional student loan reimbursement to attract providers to rural areas.
- Implement strategies to encourage more people to enter the health care workforce, particularly nurses and specialists such as respiratory therapists and mental health professionals. These strategies could include innovative programs between schools and hospitals; initiatives for better education and training; and financial support such as education grants and loan forgiveness.
- Support hospitals that want to hire international travel nurses by promoting faster and more efficient placement.
- Address excessive pricing among domestic medical staffing and travel nursing agencies.
- Assist hospitals in addressing the pressing need for more mental and behavioral health resources for the health care workforce. One suggestion included supporting hospitals to obtain expertise in helping hospital staff avoid burnout and address PTSD. Toward this end, the government could create an online platform of support tools for hospitals that focus on health care workers' mental health and well-being.

Developing education campaigns regarding vaccines and other public health issues

Hospitals expressed concerns about vaccine hesitancy and that the pandemic has led to an erosion of public trust in hospitals' safety and credibility during the pandemic.

Hospitals indicated that it would be helpful for government to:

- Broaden the public education campaign to promote vaccination, focusing on the safety and importance of getting vaccinated, ensuring that the messaging

is consistent across government entities and is up to date with the current scientific developments.

- Broaden educational campaigns relaying the importance of using masks and continuing social distancing measures, even after being vaccinated, until public health officials determine these measures can be eased.
- Assist hospitals in their efforts to publicly message that hospitals are safe venues to receive routine care (e.g., preventive screenings) and emergency care, and reinforce the importance of obtaining routine care to prevent poor health outcomes.

Providing ongoing support on financial issues

Hospitals expressed concerns about their financial stability as the COVID-19 pandemic had increased their costs and decreased their revenues.

Hospitals indicated that it would be helpful for government to:

- Allow hospitals more time to spend Federal relief funds to use the funds to complete ongoing projects, such as facility improvements and expansions.
- Provide additional guidance on the Medicare Accelerated and Advance Payment Program, Provider Relief Funds (PRF), and the Paycheck Protection Program (PPP) relating to how funds can be used and what documentation is needed to justify expenditures. Hospitals also asked for loan forgiveness or longer timelines for loan repayment.
- Continue financial support, as needed, especially for rural hospitals, critical access hospitals, and hospitals that serve underserved communities.
- Ensure that telehealth reimbursement policies account for the level of resources needed to provide telehealth services, including services for which there are provider shortages such as specialty care.

Leading a coordinated emergency response

Hospitals described opportunities for support from government related to emergency planning, preparedness, and response to COVID-19 and future public health emergencies.

Hospitals indicated that it would be helpful for government to:

- Establish expectations for regional coordination of response efforts (e.g., collaboration with neighboring health systems on resource availability) and institute regional centers for coordination.
- Foster improved management of interhospital transfers and discharge of patients to places where they will receive the best followup care, such as by

taking a greater role in facilitating connections between all parts of the health care system.

- Simplify COVID-19 data reporting across Federal, State, and local governments and eliminate any duplicative or non-essential reporting.
- Oversee national supply chains for medical supplies like PPE to combat price gouging and substandard products and to ensure greater efficiency and equity.
- Focus on the sufficiency, management, and quality of supplies in the National Stockpile in preparing for future spikes in demand for PPE and supplies, such as by supporting private sector domestic suppliers, vendors, or manufacturers to reduce reliance on imports.

LOOKING FORWARD

Addressing Urgent and Systemic Challenges Exacerbated by the COVID-19 Pandemic

This pulse survey offers insights from hospitals into the ways in which the COVID-19 pandemic has exerted significant strains on their capacity to care for patients, staff, and communities. In late February 2021, nearly 1 year into the pandemic, hospitals reported that operating in "survival mode" for an extended period of time has created new and different problems than experienced earlier in the pandemic and exacerbated longstanding challenges in health care delivery, access, and health outcomes. Hospitals detailed significant challenges related to health care delivery, staffing, vaccination efforts, supplies, and financial stability.

Hospitals, HHS, and other Federal, State, Tribal, and local entities have taken steps to address these challenges. Additionally, hospital administrators identified areas in which continued government support could help in responding to COVID-19. These included:

- enhancing knowledge and guidance on the prevention and treatment of COVID-19, including safe means to discharge COVID patients;
- addressing current staff shortages, as well as staff burnout and trauma;
- supporting vaccination efforts, including public messaging campaigns;
- assisting hospitals in managing their financial stability, especially to ensure care for underserved communities; and
- ensuring a coordinated emergency response to COVID-19.

At the same time, hospitals are grappling with many strains that emanate from systemic challenges that the COVID-19 pandemic has both drawn attention to and worsened. Better containment and management of COVID-19 alone will not resolve these systemic problems, which warrant further attention. These include:

- reducing disparities in access to health care and in health outcomes;
- building and maintaining a more robust health care workforce; and
- strengthening the resiliency of our health care system to respond to pandemics and other public health emergencies and disasters.

The hospitals' front-line perspectives provide an important voice, among many, for HHS to consider as it leads and engages in national dialogues and policymaking to help solve these foundational challenges.

SELECTED HOSPITAL STRATEGIES

Hospitals described many strategies that they have employed to help deal with strains placed on them by the COVID-19 pandemic. The following list is not exhaustive of all strategies that hospitals reported but includes those that most directly address the challenges described previously in this report. These strategies are self-reported by the hospitals; OIG did not assess their effectiveness.

Health Care Delivery

Sharing best practices for patient care

Hospitals relied on staff training and medical specialists to share current best practices related to standards of care. For example, one hospital described hiring a pulmonology consultant to go on rounds with clinical teams and reinforce the latest care standards.

Facilitating patient transfer and discharge

Hospitals relied on resource networks and communication with other hospitals to facilitate transfer and discharge of patients. Hospitals that were part of networks or could access regional systems navigated capacity challenges by using these systems to identify open beds for patient transfers. Hospitals used a variety of methods to augment their ability to facilitate patient placements, including getting assistance from the professional staff at State emergency response centers and the National Disaster Medical System and developing relationships with a local hospital network with greater capacity.

Encouraging patients to resume routine medical care

Hospitals employed strategies to encourage patients to not delay medical care. These strategies included targeted outreach, such as hospital staff personally contacting higher-risk patients with underlying health conditions and prioritizing visits for those patients.

Rebuilding trust in hospitals

Hospitals took steps to rebuild the public's trust in hospitals as safe places to receive medical care and reduce fear of COVID-19 exposure in the hospitals. Hospitals reassured the public of hospitals' safety measures such as testing, isolation, and cleaning. Hospitals used newspapers, social media, radio, and meeting with community groups and leaders to communicate these messages.

Staffing

Addressing employee burnout

Hospitals reported establishing assistance programs and other social supports to help bolster employee morale and address burnout. These efforts included using new or existing employee assistance programs and mental health services to share coping strategies. Hospitals encouraged staff to share their experiences through support groups and in one-on-one conversations, such as with counselors or chaplains.

Maintaining sufficient staffing

Hospitals reported reallocating staff from different departments or supplementing their workforce with staff from other hospitals within their networks. Hospitals reported offering staff higher pay, overtime incentives, bonuses, and additional benefits. Hospitals also recruited new graduates with less experience and nurses from other countries to fill vacancies.

Vaccinations

Leveraging resources to provide vaccinations

Hospitals partnered with government entities, retired health care workers, and other health care providers to staff vaccination sites. One hospital partnered with area pharmacies to shift the burden away from the hospital. Another hospital collaborated with local homeless shelters and churches to increase access.

Encouraging vaccinations and overcoming vaccine hesitancy

Hospitals made concerted efforts to provide their communities with accurate, complete information about vaccines. These efforts included coordinating town hall meetings, physician-led talks, press releases and one-on-one communication to convey the safety and efficacy of the vaccine. One hospital reported that the direct calls from nurses to patients increased willingness to be vaccinated by 10 percent.

BACKGROUND

COVID-19 Emergence and Variants

COVID-19 is a highly contagious coronavirus that can be fatal in some cases.[18, 19] Common symptoms include fever, cough, shortness of breath, fatigue, and new loss of taste or smell.[20] The first U.S. patient with COVID-19 was reported on January 20, 2020.[21] In late February 2020, a hospital in California documented the first community-spread transmission of COVID-19 in the United States, meaning the illness was contracted through an unknown exposure in the community.[22] On March 11, 2020, the World Health Organization declared COVID-19 to be a pandemic.[23] As of March 18, 2021, there have been over 29 million confirmed cases in the United States, with over 530,000 deaths.[24]

According to CDC, viruses constantly change through mutation, and new variants of a virus are expected to occur over time.[25] Several new variants of the virus that causes COVID-19 were identified in fall 2020 and have since been documented in the United States, with the first being detected in December 2020.[26]

Role of Hospitals in Emerging Infectious Disease Preparation and Response

The COVID-19 pandemic has created unprecedented challenges for the U.S. hospital system.[27, 28] As front-line responders, hospitals have significant responsibilities identifying and treating patients with COVID-19. Hospitals also fill critical roles in the vaccination rollout nationwide. As the pandemic has continued and evolved, hospitals have employed both short-term solutions and long-term strategies to address the crisis.

Since 2010, the Office of the Assistant Secretary for Preparedness and Response (ASPR) has managed the Hospital Preparedness Program (HPP), which provides grants to States and localities to distribute to hospitals and health care coalitions (HCC) for improved emergency preparedness and response.[29] Under HPP, health care providers and public health entities are encouraged to form HCCs that are capable of preparing for, responding to, and recovering from emergencies.[30] During emergency response and recovery, HCCs support health care organizations during emergency response and recovery by facilitating information sharing, coordinating of incident response, and expediting resource-sharing arrangements.

Role of HHS in Emerging Infectious Disease Preparation and Response

HHS is the lead Federal agency responsible for medical support and coordination during public health emergencies, such as emerging infectious disease (EID) outbreaks.[31] HHS operating and staff divisions involved in the Federal response to EIDs, including the current COVID-19 response, include the ASPR, CDC, the National Institutes of Health (NIH), CMS, FDA, Office of the Assistant Secretary for Health (OASH), and the Office of the Surgeon General (OSG).[32, 33, 34, 35] HHS also began collaborating with the Department of Defense (DOD) in May 2020 to coordinate and accelerate the development, manufacturing, and distribution of COVID-19 medical countermeasures under a public-private partnership called Operation Warp Speed.[36]

ASPR, in addition to managing HPP, coordinates HHS's response to public health emergencies and collaborates with hospitals, health care coalitions, State and local governments, and other partners to improve readiness and response capabilities.[37, 38, 39] HHS collaborates with ASPR and CDC, and in coordination with the Secretary of Homeland Security, to maintain the Strategic National Stockpile, a reserve of drugs, vaccines and other biological products, medical devices, and other supplies to ensure the emergency health security of the United States in the event of a public health emergency.[40]

In response to COVID-19, ASPR is working with its partners to develop medical countermeasures and to provide resources to support the U.S. health care system's response. Following the declaration of a national public health emergency on January 31, 2020, ASPR's Biomedical Advanced Research and Development Authority invested more than $20 billion in 2020 to developing or procuring medical countermeasure products to combat the pandemic.[41]

Following the Ebola outbreak in 2014, ASPR designated 10 health departments and associated partner hospitals as Regional Ebola and other special pathogen treatment centers (special pathogen centers) for patients with highly infectious diseases.[42] These centers are required to maintain capability to accept patients with suspected or diagnosed illness from special pathogens within 8 hours of notification and to conduct quarterly exercises to prepare for an EID outbreak.[43] In 2020, ASPR provided $350 million to support the National Special Pathogen System, a nationwide systems-based network approach that builds on the Ebola-specific treatment network to address the needs of hospitals, health systems, and health care workers on the front lines of the COVID-19 pandemic.[44] The National Special Pathogen System includes the 10 special pathogen centers, the National Emergency Special Pathogens Training and Education Center, 62 HPP cooperative agreement recipients and their State or jurisdiction special pathogen treatment centers, and 53 hospital associations.[45]

CDC monitors and responds to public health emergencies, such as EIDs, conducts research, and provides guidance to health care providers, government entities, and

the public.[46, 47] On January 21, 2020, CDC launched an agencywide response to COVID-19. Since then, CDC has published more than 180 guidance documents to advise health care providers on topics such as hospital preparedness assessments, supply planning, and patient evaluation and testing.[48, 49] For example, in February 2021, CDC updated its infection control guidance for health care facilities, including hospitals, that details a hierarchy of strategies that health care personnel can use when PPE are in short supply or unavailable.[50, 51]

CMS oversees hospitals participating in Medicare and Medicaid by requiring them to meet Conditions of Participation, a set of minimum health and safety standards.[52, 53] To help address challenges presented by COVID-19, CMS has waived some requirements under the emergency authority set forth in Section 1135 of the Social Security Act.[54] For example, CMS has issued several blanket waivers that grant regulatory flexibility to health care providers, including flexibility in providing access to telehealth services.[55]

In support of vaccine distribution efforts, CMS has updated their Medicare payment rates for administering the COVID-19 vaccine. On March 15, 2021, the rate for a vaccine requiring two doses changed from approximately $45 to $80, reflecting updated information about the cost of administering the COVID-19 vaccine for different types of providers and suppliers. CMS is also updating its set of toolkits for providers, states, and insurers regarding the new rates so that the health care system can quickly administer the vaccines.[56, 57]

FDA is responsible for protecting public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of the Nation's food supply, cosmetics, and products that emit radiation.[58] FDA is working with hospitals and the medical industry to develop vaccines, therapies, diagnostic tests, and other medical devices while monitoring the medical supply chain during the COVID-19 outbreak.[59] FDA has also issued several EUAs for ventilators, testing products, therapies, vaccines, and other medical products.[60, 61]

NIH, within its National Institute of Allergy and Infectious Diseases (NIAID), conducts and supports research to better understand, treat, and ultimately prevent infectious, immunologic, and allergic diseases.[62] As part of the U.S. Government's response to the COVID-19 pandemic, NIAID is conducting and supporting clinical research, including clinical trials evaluating therapeutics and vaccine candidates, as well as studies of people who have recovered from infection.[63]

OASH oversees HHS's key public health offices, including the OSG and the Office of Disease Prevention and Health Promotion.[64] OASH also oversees a number of Presidential and Secretarial advisory committees and 10 regional health offices across the United States.[65] As part of its COVID-19 response, OASH reviewed individual State testing plans and offered technical assistance to help States enhance COVID-19 testing capacity.[66, 67]

OSG acts as the Nation's doctor and oversees the U.S. Public Health Service Commissioned Corps, a group of uniformed officers working throughout the Federal Government to protect, promote, and advance the Nation's public health.[68] The Surgeon General communicates scientific information and recommendations about a variety of health topics, including emerging public health threats, directly to the public through advisories, calls to action, and reports.[69, 70, 71] For example, in December 2020, the Surgeon General encouraged people who have recovered from COVID-19 to donate COVID-19 convalescent plasma, which may help infected patients suppress the virus using antibodies.[72]

Federal Financial Relief

At the beginning of the pandemic Congress passed the CARES Act, which provided grants to hospitals to help offset losses due to the pandemic.[73, 74] In addition to these grants, the CARES Act included key hospital and health care system provisions that affect Medicare and Medicaid, post-acute care, telehealth, vaccine efforts, and other areas of emergency preparedness related to COVID-19.[75]

Congress, through the CARES Act, and CMS expanded the Medicare Accelerated and Advance Payment Programs to assist hospitals and other provider types in minimizing the effects of revenue shortfalls. The Medicare Accelerated and Advance Payment Programs, which existed before the pandemic, are designed to provide emergency funding to hospitals and other providers facing cash flow disruptions from circumstances beyond their control.[76, 77] Medicare typically recovers the amounts paid under these programs by withholding payments for subsequent claims from providers.[78]

Through the CARES Act and the PPP and Healthcare Enhancement Act, the Federal Government allocated $178 billion in payments to be distributed through the PRF.[79] Qualified hospitals received PRF payments for health care-related expenses or lost revenue due to COVID-19. These distributions do not need to be repaid to the U.S. Government, assuming that hospitals comply with the terms and conditions.[80]

Some hospitals were eligible for loan programs included in the CARES Act, such as the PPP.[81] Under the PPP, loans are forgiven if employers do not lay off workers and meet other criteria.[82] In addition to PPP loans, the CARES Act appropriated $454 billion for loans to qualifying larger businesses, including hospitals and other large health care entities.[83]

The American Rescue Plan Act of 2021

Signed into law on March 11, 2021, the American Rescue Plan Act of 2021 (the Act) provides additional support for health care organizations, including hospitals, in their COVID-19 response.[84]

The Act provides funding for several COVID-19 supply chains. The bill provides $6.05 billion for the research, development, manufacturing, production, and purchase of vaccines, therapeutics, and ancillary other medical products and supplies used in the COVID-19 response.[85] Specific to investing in public health, the bill also provides $7.6 billion to qualified community health centers to support their COVID-19 response, including distribution of COVID-19 vaccines and purchasing equipment to conduct mobile vaccinations, particularly in medically underserved areas.[86]

To support rural communities, the bill provides $8.5 billion toward payments to eligible rural health care providers for related expenses and lost revenues as a result of COVID-19. These include expenses such as purchasing medical supplies and equipment, providing for an increased workforce and their training, and providing for surge capacity.[87]

The bill supports the enhancement of the workforce that is involved in the COVID-19 response. In particular, the Act provides $7.66 billion to State, local, and territorial public health departments that may be used to cover areas such as wages, recruitment, personal protective equipment, and necessary administrative costs and activities.[88] To address the nursing workforce specifically, the bill also appropriates $200 million to support scholarship and loan repayment for nursing students and nurses.[89]

The Act also provides financial support for mental health and substance use concerns in the health care workforce. The bill provides $80 million in grants that support health care providers planning, developing, operating, and participating in training activities to reduce and address suicide, burnout, mental health conditions, and substance use disorders among health care professionals.[90] Additionally, the bill provides $20 million to support a national campaign for healthy work conditions and the use of mental health and substance use disorder services by health care professionals, and $40 million toward grants for health care providers to establish, enhance, or expand programs and protocols promoting mental health among their health professional workforce.[91]

Vaccine Development and Access

Operation Warp Speed was designed to produce and deliver safe and effective COVID-19 vaccines as quickly as possible.[92, 93] As of March 1, 2021, the Federal Government had awarded more than $19 billion for several vaccine candidates and ancillary vaccine supplies.[94] FDA issued EUAs for two COVID-19 vaccines, developed by Pfizer-BioNTech and Moderna, in December 2020 and issued an EUA for a third vaccine developed by Johnson & Johnson on February 27, 2021.[95, 96] As of March 19, 2021, more than 154 million doses of COVID-19 vaccines have been delivered in the United States, and more than 118 million doses have been administered.[97]

The CDC Advisory Committee on Immunization Practices (ACIP) recommended that Federal, State, and local governments prioritize vaccinating health care personnel and

residents of long-term care facilities in the first phase of vaccine allocation (Phase 1a). ACIP recommended that vaccines should next be offered to front-line essential workers and people aged 75 years and older (Phase 1b), followed by people aged 65 to 74 years, people aged 16 to 64 years with underlying medical conditions, and other essential workers (Phase 1c).[98] States, Territories, and other local authorities developed individual vaccine prioritization and timelines, some of which differed from ACIP's recommendations.[99, 100, 101] However, all States included hospital personnel in Phase 1a of their prioritization plans, and many States allocated and distributed some of their initial vaccine doses to hospitals to administer to health care workers.[102, 103, 104] In vaccinating their personnel, hospitals across the United States therefore became some of the first providers to administer COVID-19 vaccines.[105, 106]

Related Work

OIG has undertaken extensive oversight work related to COVID-19. See the OIG COVID-19 Portal for more information.

In the April 2020 report, *Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020*, we outlined challenges that hospitals reported facing in response to COVID-19 during the early weeks of the pandemic. At that time, hospitals reported that they were largely focused on enhancing their capacity to respond to the pandemic. Hospitals reported challenges such as significant shortages in PPE, ventilators, and other supplies as demand increased across the country and around the globe. Hospitals also spoke of the challenge of needing to rapidly expand facility and staffing capacity. Finally, hospitals reported that, at the time, the lack of testing capability to detect which patients had COVID-19 negatively impacted hospital operations as they tried to prevent outbreaks among hospital patients and staff.[107]

In August 2020, we issued a toolkit, *Insights for Health Care Facility From OIG;s Historical Work on Emergency Response*, which contained lessons from OIG reports published from 2002 to 2020 about health care facility emergency response.[108] A related toolkit published in August 2020 compiled *Insights for Communities from OIG's Historical Work on Emergency Response*.[109]

In January 2021, OIG contributed to the report *Federal COVID-19 Testing Report: Data Insights from Six Federal Health Care Programs*. The report, which was issued by the Health Care Subgroup of the Pandemic Response Accountability Committee (PRAC), examines COVID-19 testing efforts for six Federal health care programs during the first 7 months following the declaration of a public health emergency.[110]

GLOSSARY OF KEY TERMS

Behavioral health: The promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.[111]

Centers for Disease Control and Prevention (CDC): The HHS operating division that is tasked with protecting the public health and safety through addressing emerging health threats, disability, and disease.

Centers for Medicare & Medicaid Services (CMS): The HHS operating division that administers the Medicare program and works in partnership with State governments to administer Medicaid, the Children's Health Insurance Program, and health insurance portability standards.

Community spread: Spread of an illness for which the source of the infection is unknown.[112]

Coronavirus disease 2019 (COVID-19): An illness of the respiratory tract that is highly contagious and can be fatal in some cases. Symptoms include a cough, a headache, a fever, new loss of taste or smell, shortness of breath, and other symptoms.[113] Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is the virus that causes COVID-19 and is often called the COVID-19 virus; its prior name was the 2019 novel coronavirus (2019-nCoV).

Critical access hospital (CAH): A rural hospital that provides outpatient and inpatient hospital services to people in rural areas. CAHs are designated by CMS, and to qualify these facilities must meet certain conditions such as: furnishing 24-hour emergency care services 7 days a week, having no more than 25 inpatient beds, and having an average length of stay of 4 days or less per patient for acute-care services. Until the end of the emergency declaration, CMS is waiving requirements that CAHs limit the number of beds to 25 and length of stay of 4 days.

Emergency use authorization (EUA): A mechanism used by FDA to allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions. EUAs are used when certain statutory criteria are met, including when there are no adequate, approved, and available alternatives.[114]

Emerging infectious disease (EID): Infections that have recently appeared within a population or those whose incidence or geographic range is rapidly increasing or threatens to increase in the near future.

Federal Emergency Management Agency (FEMA): Federal agency under the Department of Homeland Security that coordinates responses to natural disasters with State and local governments and provides Federal assistance.

Food and Drug Administration (FDA): the HHS operating division that is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our Nation's food supply, cosmetics, and products that emit radiation.

Health care coalition: A group of local health care and other public health organizations that work together to prepare for, respond to, and recover from emergencies.

HHS Protect: On April 10, 2020, the HHS Office of Chief Information Officer (OCIO), in partnership with CDC and contractors, launched this new platform to collect health care information to better inform the ongoing COVID-19 response.[115, 116] In July, HHS announced new guidance for hospitals to report requested hospital data to HHS Protect.[117] Along with data reported by hospitals report, HHS Protect integrates over 200 datasets from State, Federal, and private partners, which includes data on hospital utilization, government and industry supply chain, and other information relevant to the current pandemic.[118]

Intensive care unit (ICU): A specialized hospital or facility department that provides critical care and life support for acutely ill and injured patients.

Medical countermeasures: FDA-regulated products that may be used in potential public health emergencies, including a naturally occurring emerging disease.[119]

Medicare Accelerated and Advance Payment Programs: Programs that allow CMS to provide temporary relief through advanced or accelerated payment to providers and suppliers when they face cash flow challenges due to specified circumstances out of their control. Medicare typically recovers the amounts paid under these programs by withholding payments for subsequent claims from providers [120]

Mental health: CDC defines mental health as emotional, psychological, and social well-being. A person can experience poor mental health and not be diagnosed with a mental illness.[121]

N95 respirator mask: Respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The "N95" designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (0.3 micron) test particles. If properly fitted, the filtration capabilities of N95 respirators exceed those of face masks.

National Health Service Corps (NHSC): Administered by the Health Resources and Services Administration (HRSA), NHSC provides support to health care providers working in areas of the United States with limited access to care. In 2019, HHS announced that it would provide additional money in scholarship and loan repayment awards for clinicians and students through the NHSC.[122] The NHSC Rural Community Loan Repayment Program was designed for providers working to combat the opioid epidemic in the Nation's rural communities. In exchange for loan repayment, award recipients must commit to 3-year loan repayment contracts. The NHSC provides information on how those who have already been approved in the program can receive flexibility due to COVID-19.[123]

Negative pressure room: A room in a hospital or facility that is used to contain airborne contaminants within the room.

Office of the Assistant Secretary for Preparedness and Response (ASPR): The HHS staff division that leads the Nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies.

Pandemic: An epidemic that has spread over several countries or continents, usually affecting a large number of people.

Paycheck Protection Program (PPP): A program that provides loans to assist eligible borrowers to pay certain payroll and operating costs.[124] Borrowers may be eligible to have their PPP loan forgiven if they meet several criteria, including maintaining employee and compensation levels. The program is run by the Small Business Administration.[125, 126]

Personal protective equipment (PPE): Protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. PPE respirators and face masks.

People of color: A collective term used as an inclusive and unifying frame across different racial groups that do not identify as White.[127]

Provider Relief Fund (PRF): A fund established by Congress to reimburse, through grants or other mechanisms, eligible health care providers for health care-related expenses or lost revenues that are attributed to the coronavirus.[128]

Pulse survey: A type of short feedback survey, (e.g., quick, point-in-time questions) that are typically narrow in scope.

Quarantine: The separation and restriction of movement of people who were exposed to a contagious disease. Quarantine is used to keep an individual who may have been exposed to COVID-19 away from others.

Regional Ebola and other special pathogen treatment centers (special pathogen centers): Ten hospitals designated by ASPR following the Ebola outbreak in 2015 to maintain capability to accept patients ill from special pathogens. They receive annual assessments from the National Ebola Training and Education Center, a consortium of several health care facilities that is funded by and directly coordinates with ASPR and CDC.

Respirator: Masklike device that covers the nose and mouth to prevent the inhalation of noxious substances. There are two main types: air-purifying respirators, which remove contaminants from the air, and air-supplying respirators, which provide a clean source of air. (Also see N95 respirators)

Social distancing: Increasing the physical space between people to avoid spreading illness. Recommended measures can include keeping 6 feet away from others, avoiding social gatherings, and following guidance from local public health authorities for where a person lives.

CDC Social Vulnerability Index (CDC SVI): An index of 15 U.S. Census variables that can be used by local health officials to identify communities that may need support before, during, and after disasters.[129]

Special Pathogen: A highly infectious agent capable of causing severe disease in humans.

Small Rural Hospital Improvement Program (SHIP): HRSA's Federal Office of Rural Health Policy administers the Small Rural Hospital Improvement Program. The purpose of this program is to help small rural hospitals with 49 beds or less implement quality and operational improvement efforts to align with value-based care. The Federal Office of Rural Health Policy administers the SHIP award through the State Offices of Rural Health (SORH). Each SORH submits an application to HRSA on behalf

of eligible hospital applicants in its State. The SORH is the official award recipient of record and serves as fiscal intermediary for all eligible hospitals within the State. The maximum funding per hospital for June 1, 2019, through May 31, 2023, is $12,000 per year, subject to the availability of appropriated funds.[130]

Staffed Beds: Physical beds in a health care facility for which staff are available to attend to the patient occupying the bed.[131]

Strategic National Stockpile: Supplements State and local stocks of devices, medicines, and supplies for public health emergencies.

Telehealth: Use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

Traveling nurse: Nurses employed on a short-term or periodic basis. They include temporary staff, independent contractors, and seasonal hires.[132]

Underserved communities: Communities that have historically experienced health care disparities, including limited access to health care and worse health outcomes than other communities. Communities may be underserved due to geographic conditions, socioeconomic conditions, or a combination of both.

World Health Organization (WHO): An international organization that partners with countries, the United Nations system, research institutions, and other entities to direct and coordinate health work. WHO has delegates from member countries and an Executive Board that is composed of health experts.

METHODOLOGY

Scope of Inspection

For this evaluation we conducted a "pulse survey" (i.e., quick, point-in-time questions) by telephone with administrators from a stratified random sample of Medicare-certified hospitals nationwide. These conversations focused on three key issues regarding their COVID-19 response: (1) current challenges in responding to the COVID-19 pandemic, (2) their greatest concerns going forward, and (3) areas for government support. We analyzed hospital responses to identify common and compelling challenges, concerns, and areas for government support.

We conducted the interviews during February 22–26, 2021. We spoke with administrators who are familiar with the hospital's COVID-19 response. The positions of these hospital administrators were typically the Chief Executive Officer, Chief Medical Officer, or representatives from teams and departments dedicated to emergency preparedness or incident command. In some cases, leadership from the relevant hospital networks participated in the interviews alongside hospital administrators or on the hospitals' behalf.

Hospital Selection and Response

We had previously selected a stratified random sample of 410 hospitals for an October 2018 report examining hospital preparedness for emerging infectious diseases.[133] We randomly selected the 410 hospitals from 4,489 Medicare-certified hospitals with emergency departments in 2016. The 410 selected hospitals were in 47 States, the District of Columbia, and Puerto Rico. The sample was composed of two strata: (1) all 10 ASPR-designated Special Pathogen Centers and (2) 400 other hospitals with emergency departments.

For this review, we used the same sample of 410 hospitals but removed 13 hospitals that were no longer in operation or no longer providing inpatient care. This left a total sample of 397 eligible hospitals that we attempted to contact. We received responses from 320 of these 397 hospitals, for an 81-percent rate of contact. Among the 77 hospitals that did not respond, 5 chose not to participate, 20 were unable to provide the necessary staff to schedule interviews during the 5-day data collection period, and 52 could not be reached after a minimum of 3 attempts to contact them.

Most interview responses were provided directly by an administrator for a single hospital. However, for 51 sampled hospitals, we spoke with administrators from their parent corporations. We considered the interviews with the administrators from the parent companies to be responses for each of the hospitals in our sample that were

owned by those companies. These 51 hospitals were spread across 16 hospital networks.

HHS Protect Data

To supplement the pulse survey responses, we analyzed data from HHS Protect that hospitals reported for the Wednesday before our interviews (February 17, 2021). We chose this date because we wanted data as close to our survey week as possible, and because certain data are reported only for Wednesdays. For each responding hospital, we identified or calculated the following:

- number of staffed adult inpatient beds,
- whether the hospital was treating any patients with COVID-19,
- adult inpatient occupancy rate,
- adult ICU occupancy rate,
- whether the hospital was able to order and obtain N95 masks, and
- whether the hospital anticipated a critical staffing shortage within a week.[134]

See the Appendix on page 41 for the data presentation of this information.

To complete this analysis, we analyzed HHS Protect data from both the Hospital Unified Prioritized Timeseries and Hospital Denominator datasets. We defined each hospital using the CMS Certification Number as reported in HHS Protect. Our analysis is reflective of what hospitals had reported to HHS Protect as of February 25, 2021. We did not determine whether hospitals provided updated data after this date. Four responding hospitals had not reported to HHS Protect for February 17, 2021; thus, this analysis includes 316 of the 320 responding hospitals.

CDC and U.S. Census Bureau Data

We also obtained community-level socioeconomic and demographic data from the CDC's 2018 Social Vulnerability Index database and U.S. Census Bureau's 2019 American Community Survey and the 2010 decennial census. These data allowed us to examine the community characteristics within a 30-minute drive of each responding hospitals or within the hospital's county.

We examined three geospatial variables:

- urban, mid-size, or rural designation;
- a social vulnerability index; and
- the proportion of the population, by county, that had household incomes below the Federal poverty level.

See the Appendix on page 41 for the data presentation of this information.

Limitations

This study has two limitations: (1) hospital responses reflect a point in time (February 22–26, 2021)—since our interviews, some hospital challenges may have worsened and others may have improved; and (2) we did not independently verify the information reported by hospitals to HHS Protect or to OIG during the interviews, nor have we independently assessed the merits, costs, or effectiveness of the strategies or areas for government support identified by hospitals. As such, OIG is not endorsing the suggestions made by the hospital administrators.

Standards

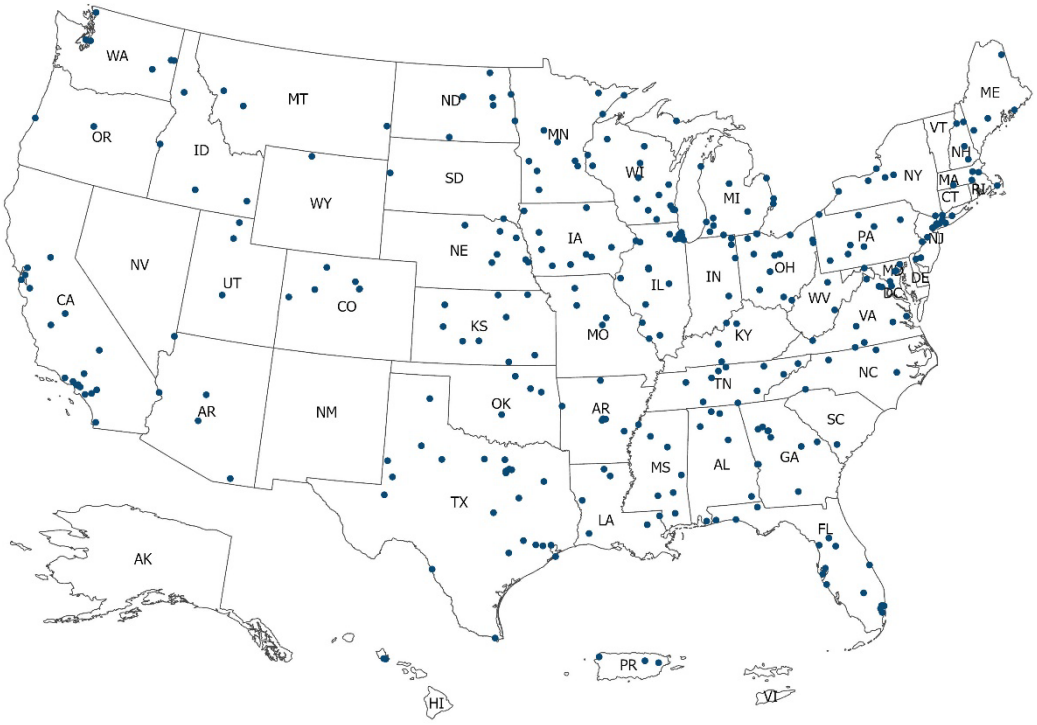
We conducted this study in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX

Characteristics of Responding Hospitals and Their Communities

This appendix describes the 320 hospitals that we surveyed, as well as the communities surrounding the responding hospitals. Please refer to the methodology section for an explanation of the data collected and analyzed for this appendix.

Exhibit A-1: The 320 responding hospitals were located in 45 States, the District of Columbia, and Puerto Rico.



Source: OIG analysis of 320 responding hospitals using the address listed for their provider number, March 2021.

Exhibit A-2: Among the responding hospitals, some were designated as specialized hospitals.

Special pathogen centers are designated to treat patients with infectious diseases. We talked to 9.

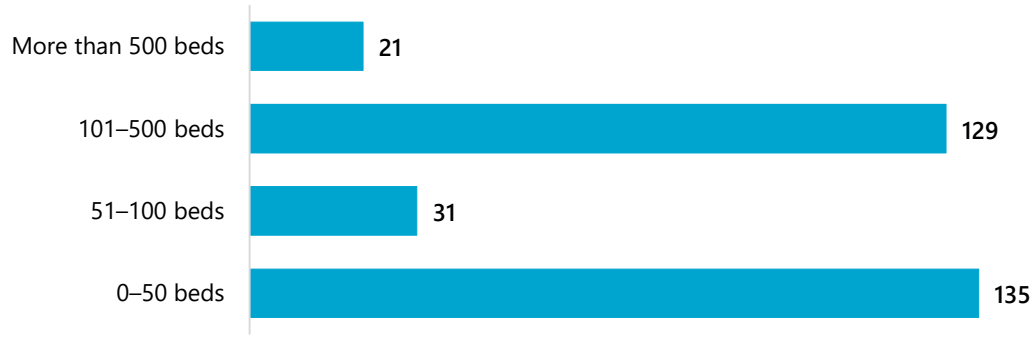
Major teaching hospitals are affiliated with medical schools. We talked to 24.

Critical access hospitals are smaller hospitals typically in rural communities. We talked to 95.

Source: OIG analysis of CMS's Certification and Survey Provider Enhanced Reports data associated with a sample of Medicare-certified hospitals as well as data obtained from https://www.phe.gov/Preparedness/planning/hpp/Pages/hpp-pathogens.aspx, March 2021.

Note: We did not include any of the special pathogen centers in the count of major teaching hospitals.

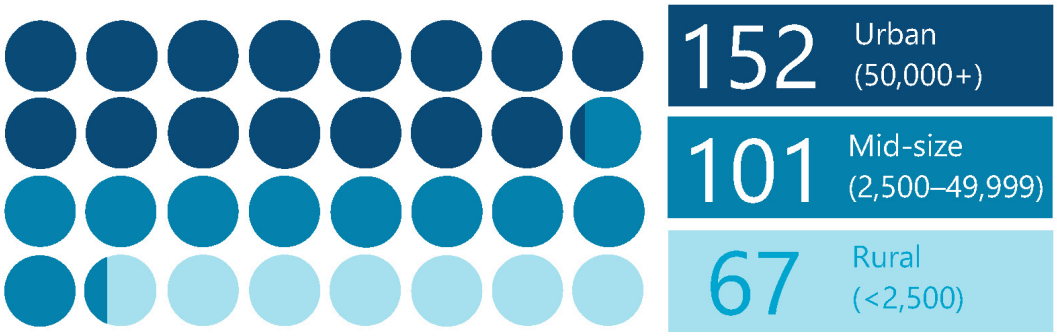
Exhibit A-3: Responding hospitals had a range of bed counts.



Source: OIG analysis of HHS Protect data for staffed, inpatient beds for adults, March 2021.

Note: Total equals 316 responding hospitals because not all hospitals reported data in HHS Protect.

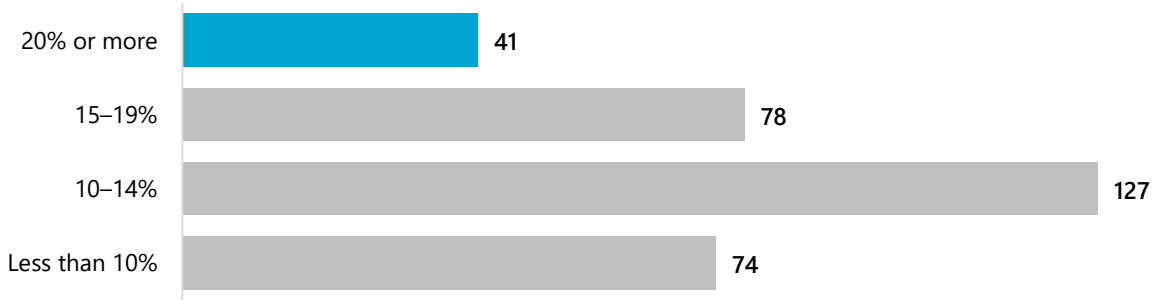
Exhibit A-4: About half of responding hospitals were located in urban areas.



Source: OIG analysis of 2010 U.S. Census Bureau data for the 320 responding hospitals using the address listed for their provider number, March 2021.

Note: One dot is equivalent to 10 hospitals.

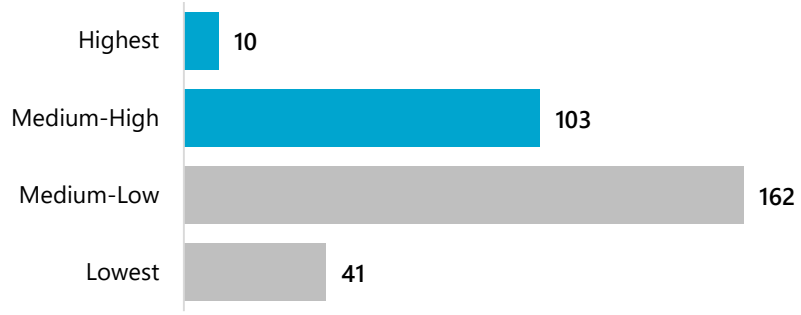
Exhibit A-5: Among responding hospitals, 41 were located in counties where 20 percent or more of the population had household incomes below the Federal poverty level.



Source: OIG analysis of 2019 U.S. Census Bureau data for 320 responding hospitals, March 2021.

Note: Nationally, by county, the average percentage of the population with household income below the Federal poverty level was 12.3 percent. See U.S. Census Bureau, "Small Area Income and Poverty Estimates: 2019." Accessed at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p30-08.pdf on March 15, 2021.

Exhibit A-6: More than one-third of responding hospitals (113) were in communities with higher social vulnerability than the national average.



Source: OIG analysis of 2018 CDC data for 316 responding hospitals, March 2021.

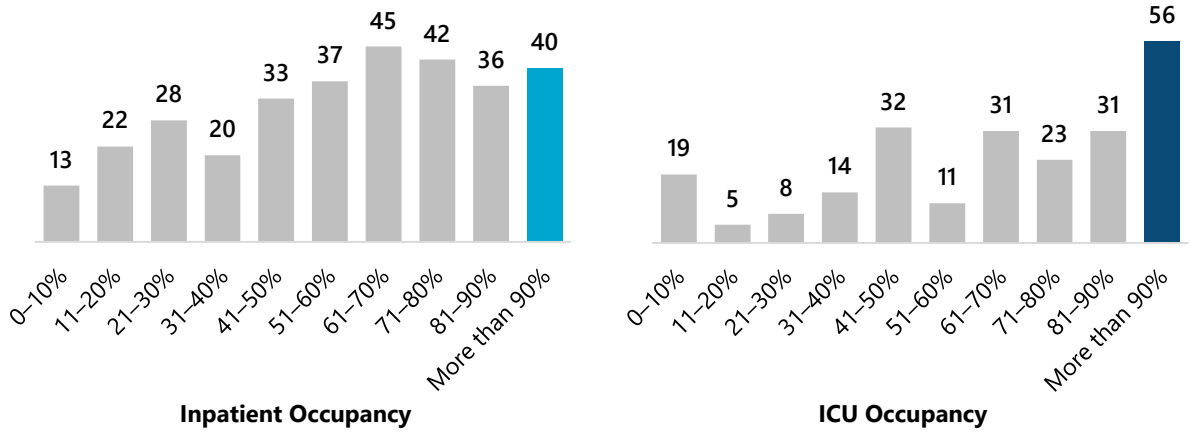
Note: The social vulnerability score uses CDC's social vulnerability index of the community and we calculated this score within a 30-minute drive from each hospital. The index ranges from 0 to 1.0, with 0.5 being the midpoint. Highest are those above 0.75, medium-high are >0.50 to 0.75, medium-low are >0.25 to 0.50, and lowest are those less than or equal to 0.25. For more information about CDC's Index, see https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Exhibit A-7: The majority of responding hospitals were treating adult inpatients with confirmed or suspected cases of COVID-19 a week before our data collection.

Source: OIG analysis of HHS Protect data, March 2021.

Note: Total equals 316 responding hospitals because not all hospitals reported data in HHS Protect.

Exhibit A-8: Some responding hospitals were operating at over 90-percent adult inpatient occupancy and/or over 90-percent adult ICU occupancy a week before our survey.



Source: OIG analysis of HHS Protect data for February 17, 2021.

Note: For adult inpatient occupancy, the total equals 316 responding hospitals because not all hospitals reported data in HHS Protect. For adult ICU occupancy, the total equals 230 because we excluded 86 hospitals that reported having no staffed ICU beds for adults.

Exhibit A-9: Number of Responding Hospitals That Reported Experiencing Staffing Shortages and Difficulties Obtaining Supplies

Indicator	Number of Hospitals
Staffing Shortages	
Reported that they faced a critical staffing shortage as of February 17, 2021	38
Reported that they anticipated facing a critical staffing shortage within a week	49
Difficulty Obtaining Supplies	
Reported that they were unable to order or obtain N-95 masks	19

Source: OIG analysis of HHS Protect data, March 2021.

Note: For experiencing staffing shortages, 296 respondent hospitals reported data. For difficulties in obtaining N-95 masks, 316 responding hospitals reported data.

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Rosemary Rawlins Bartholomew and Ivy Ngo served as the team leaders for this study. Key contributors included Ariel Arguelles, Emily Borgelt, Anna Brown, Charis Burger, Kristen Calille, Tanaz Dutia, Ben Gaddis, Kevin Golladay, Jennifer Hagen, Eunji Kim, Sarah Lee, Demetrius Martinez, Kasey Memphis, Sabrina Morello, Petra Nealy, Chelsea Samuel, Karl Mari Santos, Anthony Soto McGrath, Savanna Thielbar, Jesse Valente, and John Van Der Schans.

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This report was prepared under the direction of Blaine Collins and Ruth Ann Dorrill, Regional Inspectors General for Evaluation and Inspections, and Abby Amoroso and Amy Ashcraft, Deputy Regional Inspectors General.

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To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ABOUT THE OFFICE OF INSPECTOR GENERAL

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No.2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

Lauren Margolis, *State deploys nurses to help East Texas hospitals with staffing shortages*, KETK.com (Aug. 19, 2021)

EXHIBIT A-3

CORONAVIRUS

State deploys nurses to help East Texas hospitals with staffing shortages

by: Lauren Margolis

Posted: Aug 19, 2021 / 06:39 PM CDT / Updated: Aug 19, 2021 / 06:40 PM CDT

LIST: Latest vaccination rates for East Texas zip codes after CDC recommends booster shots →

Gov. Greg Abbott announced **the state is stepping in** to help recruit out-of-state medical workers.

One of the hospitals to receive the help is **UT Health East Texas**.

UT Health's Chief Medical Officer Dr. Thomas Cummins said about 20 nurses and respiratory therapists made it to East Texas with more expected to arrive in the coming days.

"Having experienced ICU and medical nurses and ER nurses to be able to help take care of patients is an invaluable asset to have and certainly helps bring some relief to some very tired staff members," Cummins said.

He said the staff is working hard to care for **hospitalized East Texans that have contracted COVID-19**.

Around 21% of all patients in our hospitals are fighting coronavirus.

He said even more help is needed than January when COVID-19 numbers were similar to now.

> **Can health insurance companies charge the unvaccinated higher premiums? What about life insurers? →**

"Back in January this year, we had close to 300 RAC nurses, with a census as much lower as currently, now we're looking at some 20, with a record high census," Cummins said.

He added that the UT Health system sets a new record everyday for the number of hospitalized COVID patients.

While they are getting state assistance, he said the amount of workers just isn't enough.

"While it's certainly helpful and appreciated, it's certainly not making the impact that we saw earlier in the year in it's ability to help us open beds and take care of people," Cummins said.

The patients who can't get into hospitals are going to free-standing ER's, leaving staff to care for a level of patients they never have before.

Other medical facilities like free-standing emergency rooms aren't approved to receive help from the state right now, but are also experiencing a staff shortage.

"We're having to take care of not only emergency care patients but also ICU level care patients," said Jeffrey Beers, a physician at Hospitality Health ER.

> **What is the lambda variant and how contagious is the strain of COVID-19? →**

emergency room nurses," Beers said.

He said they are doing what they can to find more workers and hoping the help they need comes soon.

This Portable Heater Might Be the Least Expensive Heating for Texas Homes

Alpha Heater

The Strangest RVs in America, #5 Will Crack You Up

Yeah Motor

The First Ladies Were Just Ranked (You'll Never Guess Who's #1)

MoneyWise.com

Quiz: Can You Match These Movies to Their Posters?

UpbeatNews

Unhealthiest American Groceries You Should Never Buy (#1 Will Surprise You)

MoneyWise.com

EMPTY SHELVES: Why there are so many shortages, when we can expect them to end

by Lauren Margolis / Nov 15, 2021

TYLER, Texas (KETK) - It's hard to find anything these days, from school supplies for students, groceries for your family, and even pet supplies for furry friends.

"I've seen sticky notes everywhere, you know...call this person when this gets in so yeah there is a little list you might say," said Judy Parsons, a Petsmart Employee.

Read the Full Article →

9-year-old Astroworld concertgoer dies, death toll now 10

by Aleksandra Bush / Nov 15, 2021

(NewsNation Now) — A 9-year-old boy has died of the injuries he suffered at Astroworld more than a week after the event, according to the mayor of Houston.

Ezra Blount attended the concert with his father. The family says he was trampled after his dad passed out.

Read the Full Article →

by Jasmine Cooper, Nexstar Media Wire / Nov 14, 2021

(NewsNation Now) — A Southwest Airlines employee was assaulted and hospitalized after being punched in the head by an unruly female passenger on a flight, police said Sunday.

The incident occurred during the boarding process for Southwest Flight 4976 from Dallas Love Field airport to New York's La Guardia airport on Saturday.

Read the Full Article →

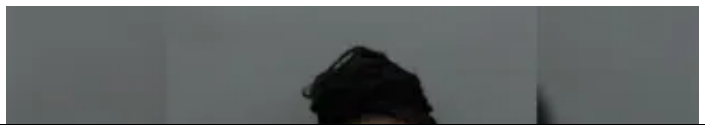
TOP STORIES

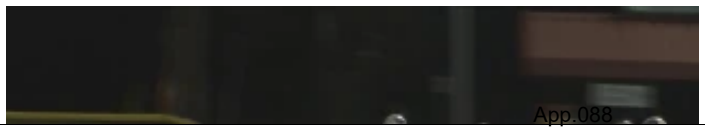
1 man dead after motorcycle wreck in Marion County

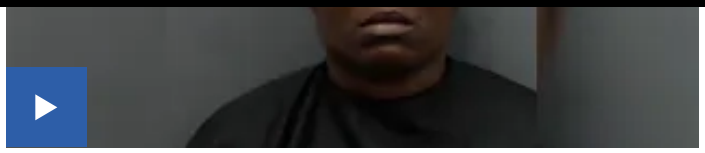
Funeral held for Texas teen who died at Astroworld festival

Wedding bells back in full swing with East Texas Wedding Extravaganza in downtown Tyler

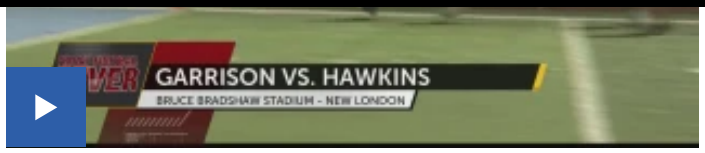
2 arrested for suspected role in bomb threat made to Mineola High School







Longview arrest woman involved with stabbing that leaves 1 hospitalized



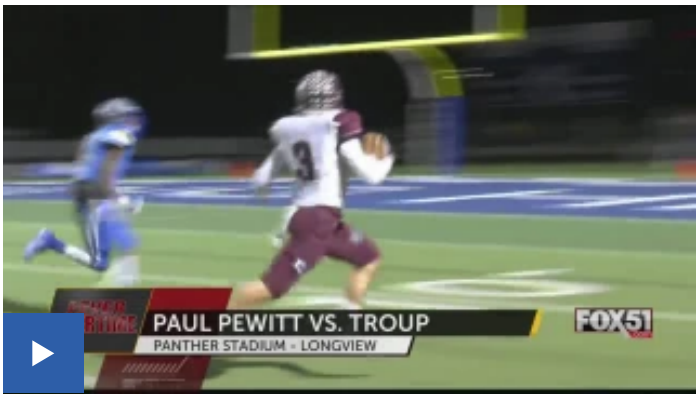
Hawkins moving on to area-round after win over Garrison

Tatum falls to Pottsboro in first round of 2021 playoffs

Undefeated Van moving on to area-round following win over Liberty-Eylau

Carthage one step closer to another title after Friday win over Gatesville

Mineola takes down Sabine in bi-district round of playoffs



SPOTLIGHT GAME: Troup wins Bi-District playoff

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MORE STORIES

Chapel Hill community mourn deaths of 14-year-old boy, mother involved in 5-vehicle fatal crash

US appeals court halts Biden's COVID-19 vaccine mandate

Gas leak shut off after affecting Henderson, Van Zandt County residents; shelter-in-place remains for Van Zandt County until 9 a.m.

East Texans can visit the Annual Heritage Syrup Festival in Henderson this weekend

Read more stories →

TRENDING RIGHT NOW

1. **Texas Workforce Commission offering 12 months free child care, here's how**
2. **EMPTY SHELVES: Why there are so many shortages, when we can expect them to end**
3. **LIVE: Beto O'Rourke officially announces run for Texas Governor**
4. **2 arrested for suspected role in bomb threat made to Mineola High School**
5. **9-year-old Astroworld concertgoer dies, death toll now 10**

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Home for the Holidays

Thanksgiving Giveaway 2021

Enter KETK Pro Football Challenge

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COMMUNITY CALENDAR

East Texas Events

DEC 11	**Tyler Flag Football Tournament Sa...**	Tyler Legacy Footb... | Tyler, TX
MON 15	**Steel Band Concert**	Stephen F. Austin ... | Nacogdoches, TX
MON 15	**Music & Movement - Online**	Longview Public Li... | Longview, TX
MON 15	**It's a Wrap!**	12685 SH 323 E | Overton, TX
MON 15	**Trivia Night At The Pint**	Pint and Barrel Dr... | Palestine, TX

MON 15 | TUE 16 | WED 17 | THU 18 | FRI 19 | SAT 20

See all events | Add your event

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

Governor Abbott Takes Action to Expand Nursing Workforce

EXHIBIT A-4

Governor Abbott Takes Action to Expand Nursing Workforce

March 21, 2020 | Austin, Texas | Press Release

Governor Greg Abbott has waived several regulations to help meet Texas' growing need for nurses as the state responds to the COVID-19 virus. The Governor's actions will expand Texas' active nursing workforce by doing the following:

- Allowing temporary permit extensions to practice for graduate nurses and graduate vocational nurses who have yet to take the licensing exam.
- Allowing students in their final year of nursing school to meet their clinical objectives by exceeding the 50% limit on simulated experiences.
- Allowing nurses with inactive licenses or retired nurses to reactivate their licenses.

"In the coming weeks and months, Texas will continue to see a growing need for medical professionals to help us respond to these unique and challenging times," said Governor Abbott. "With these actions, Texas is taking an important step to meet that need. Nurses are essential to our ability to test for this virus, provide care for COVID-19 patients, and to continue providing other essential health care services. Suspending these regulations will allow us to bring additional skilled nurses into the workforce to assist with our efforts and enhance our COVID-19 response."

Office of the Texas Governor
P.O. Box 12428
Austin Texas 78711
(512) 463-2000

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

Texas Physician Supply and Demand Projections, 2018 – 2032

EXHIBIT A-5

Texas Physician Supply and Demand Projections, 2018 - 2032

As Required by

Texas Health and Safety Code

Section 105.009

May 2020

TEXAS
Health and Human Services

Texas Department of State Health Services

Table of Contents

Executive Summary

In accordance with Texas Health and Safety Code, Section 105.009, the Health Professions Resource Center at the Texas Department of State Health Services (DSHS) is required to conduct research identifying those specialties and subspecialties in the state that are at critical shortage levels, the overall supply of physicians in the state, and the ability of the state's graduate medical education system to meet the current and future health care needs of the state. This report is in fulfillment of the requirements in Section 105.009 and is an update to the 2018 DSHS supply and demand projections report for primary care physicians and psychiatrists. This report replaces the 2018 report.

For this report, DSHS summarized results from supply and demand projections for all physicians and 35 physician specialties from 2018 through 2032. These results are based on the Health Workforce Model created by IHS Markit, a consulting firm that has previously conducted health care workforce modeling for the Health Resources and Services Administration, the Association of American Medical Colleges, and DSHS.

To project supply, the model used physician licensure data provided by the Texas Medical Board and projected medical school enrollment and graduate medical education residency position data provided by the Texas Higher Education Coordinating Board, as well as hours worked and retirement data from other validated sources. To project demand, the model used national and state data from the American Community Survey and the Behavioral Risk Factor Surveillance System, national data from the American Medical Association Masterfile, county population projections from the Texas Demographic Center, county-level demographic counts from the U.S. Census Bureau, and other sources.

Key findings include the following:

- The shortage of all physicians statewide is projected to increase from 6,218 full-time equivalents (FTEs) in 2018 to 10,330 FTEs in 2032.
- Among the 35 physician specialties included in this report, general internal medicine is projected to have the greatest absolute shortage in 2032, as an additional 2,607 FTEs will be needed statewide to meet projected demand.

- Among the 35 physician specialties included in this report, family medicine is projected to have the greatest shortage increase in FTEs between 2018 and 2032, as the shortage of family medicine physicians statewide is projected to increase from 1,034 FTEs in 2018 to 2,495 FTEs in 2032.
- Physician specialties identified as critical shortages vary by region. For instance:
    - Psychiatry is identified as a critical shortage in all regions of the state except Central Texas (Region 7).
    - Pediatrics is identified as a critical shortage in all regions of the state except the Gulf Coast (Region 6/5S) and Central Texas.
    - Family medicine is identified as a critical shortage in all regions of the state except the Panhandle (Region 1), North Texas (Region 2/3), Central Texas, and South Texas (Region 8).

In summary, there is a shortage of physicians in Texas and this shortage will increase through 2032. Current projections in medical school enrollment and resident positions by the Texas Higher Education Coordinating Board indicate that the state's graduate medical education system will not create a supply of physicians that can meet projected demand.

1. Introduction

Senate Bill 18, 84th Legislature, Regular Session, 2015, added Section 105.009 to the Texas Health and Safety Code. Section 105.009 requires that the Health Professions Resource Center (HPRC) at the Texas Department of State Health Services (DSHS) conduct research identifying those specialties and subspecialties in the state that are at critical shortage levels, the overall supply of physicians in the state, and the ability of the state's graduate medical education system to meet the current and future health care needs of the state. By May 1 of even-numbered years, the Statewide Health Coordinating Council is required to report the results of research conducted by HPRC to the Legislative Budget Board, the Texas Higher Education Coordinating Board, the Office of the Governor, and the standing committees of each house of the legislature with primary jurisdiction over state finance or appropriations. This report is in fulfillment of the requirements in Section 105.009 and is an update to the 2018 DSHS supply and demand projections report for primary care physicians and psychiatrists. This report replaces the 2018 report.

This report assesses the physician shortage level in Texas by presenting supply and demand projections for all physicians and 35 physician specialties from 2018 through 2032. These projections are based on the Health Workforce Model created by IHS Markit, a consulting firm that has previously conducted health care

workforce modeling for the Health Resources and Services Administration,[1] the Association of American Medical Colleges,[2] and DSHS.[3,4,5]

This report is organized into six sections beginning with a brief introduction and the background and objectives of this report. Section 3 describes the methodology for the supply and demand models used for the projections in this report and discusses the strengths and limitations of these projections. Section 4 presents the supply and demand projections for all physicians and 35 physician specialties statewide from 2018 through 2032. Section 5 identifies critical shortages of physician specialties by public health region. Section 6 provides report conclusions.

Three appendices appear at the end of this report. Appendix A provides tables that include the regional supply and demand projections for 35 physician specialties for 2018 and 2032. Appendix B provides information on Texas Health Data, an interactive public data system displaying the statewide and regional supply and demand projections for all physicians and 35 physician specialties from 2018 through 2032. Appendix C provides a map of Texas' eight public health regions and information on where the public may identify the region in which specific counties are located.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf. Published November 2016. Accessed January 28, 2020.

[2] Association of American Medical Colleges. 2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032. https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Published April 2019. Accessed January 28, 2020.

[3] Texas Department of State Health Services. Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017 - 2030. http://dshs.texas.gov/legislative/2018-Reports/SB-18-Physicians-Workforce-Report-Final.pdf. Published July 2018. Accessed January 28, 2020.

[4] Texas Department of State Health Services, Texas Center for Nursing Workforce Studies. Nurse Supply and Demand Projections, 2015-2030. https://www.dshs.texas.gov/chs/cnws/WorkforceReports/SupplyDemand.pdf. Published October 2016. Accessed January 28, 2020.

[5] Texas Department of State Health Services. Texas Supply and Demand Dental Projections, 2018 – 2030. https://www.dshs.texas.gov/chs/hprc/publications/DSHS_DentalProjections_092019.pdf. Published September 2019. Accessed January 28, 2020.

2. Background

The availability of providers and facilities to patients has been recognized as one of the top barriers to meeting the health care needs of the United States population.[6] Availability is defined as "the relationship of the volume of existing services and resources to patients' volume and types of needs." In 2018, the number of active physicians on a per 100,000 population basis was 277.8 nationwide, while the corresponding number for Texas was 224.8.[7] Moreover, Texas ranked 41st among the 50 states in the number of active physicians per 100,000 population.

According to the Bureau of Labor Statistics, the projected job growth of physicians and surgeons nationwide from 2018 to 2028 is faster than average at 7 percent.[8] Demand for health care services is projected to increase due to the aging and growing population.

In 2019, the Association of American Medical Colleges issued a report projecting the supply and demand for physicians nationally from 2017 to 2032.[9] Results from this report indicate that there will be an estimated shortage of between 46,900 and 121,900 physicians nationwide by 2032. This projected shortage includes 21,100 to 55,200 primary care physicians and 24,800 to 65,800 specialty care physicians.

As required by Texas Health and Safety Code, Section 105.009, DSHS issued a report in 2018 projecting the supply and demand for primary care physicians and

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[6] Kullgren JT, McLaughlin CG, Mitra N, Armstrong K. Nonfinancial barriers and access to care for U.S. adults. *Health Serv Res*. 2012;47(1 Pt 2):462-485.

[7] Association of American Medical Colleges. 2019 State Physician Workforce Data Report. https://store.aamc.org/downloadable/download/sample/sample_id/305/. Published November 2019. Accessed January 29, 2020.

[8] U.S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook, Physicians and Surgeons. https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm. Accessed January 29, 2020.

[9] Association of American Medical Colleges. 2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032. https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Published April 2019. Accessed January 28, 2020.

psychiatrists in Texas at both the state and regional level from 2017 to 2030.[10] Results from this report indicated that there would be an estimated shortage of 3,375 full-time equivalent (FTE) primary care physicians and 1,208 FTE psychiatrists statewide by 2030.

This report replaces the 2018 DSHS supply and demand projections report for primary care physicians and psychiatrists. The Health Workforce Model used to project supply and demand in the 2018 report has been updated for this report to include more recent sources of data. Thus, the projections in this report replace those from the 2018 report. This report identifies the degree of shortage of all physicians and 35 physician specialties in Texas. Results are reported statewide, and critical shortages of physician specialties are identified in each of the state's eight public health regions. The supply and demand projections presented in this report are from the baseline year of 2018 through 2032.

This report aims to inform state officials and stakeholders regarding areas of critical physician shortage. By doing so, this report may assist in the development of policies that address the availability of the physician workforce in Texas.

Objectives

The primary objectives of this report are to:

- Project supply and demand for all physicians statewide;
- Project supply and demand for 35 physician specialties statewide; and
- Identify critical shortages of physician specialties by public health region.

[10] Texas Department of State Health Services. Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017 - 2030. http://dshs.texas.gov/legislative/2018-Reports/SB-18-Physicians-Workforce-Report-Final.pdf. Published July 2018. Accessed January 28, 2020.

3. Methodology for Supply and Demand Projections

Projected supply and demand for all physicians and 35 physician specialties are estimated for Texas statewide and by public health region using IHS Markit's Health Workforce Model. This model has previously been utilized by the Health Resources and Services Administration,[11] the Association of American Medical Colleges,[12] and DSHS[13,14,15] for health care workforce modeling.

The model includes two parts: the Health Workforce Supply Model (HWSM) and the Healthcare Demand Microsimulation Model (HDMM). The HWSM generates the supply projections and the HDMM generates the demand projections. Both models use a microsimulation approach for which the unit of analysis is the individual: in this case, providers for the HWSM and patients for the HDMM. Information about the models contained within this report is based on IHS Inc.'s Health Workforce Model Documentation.[16]

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[11] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis. National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025. https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf. Published November 2016. Accessed January 28, 2020.

[12] Association of American Medical Colleges. 2019 Update: The Complexities of Physician Supply and Demand: Projections from 2017 to 2032. https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Published April 2019. Accessed January 28, 2020.

[13] Texas Department of State Health Services. Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017 - 2030. http://dshs.texas.gov/legislative/2018-Reports/SB-18-Physicians-Workforce-Report-Final.pdf. Published July 2018. Accessed January 28, 2020.

[14] Texas Department of State Health Services, Texas Center for Nursing Workforce Studies. Nurse Supply and Demand Projections, 2015-2030. https://www.dshs.texas.gov/chs/cnws/WorkforceReports/SupplyDemand.pdf. Published October 2016. Accessed January 28, 2020.

[15] Texas Department of State Health Services. Texas Supply and Demand Dental Projections, 2018 – 2030. https://www.dshs.texas.gov/chs/hprc/publications/DSHS_DentalProjections_092019.pdf. Published September 2019. Accessed January 28, 2020.

[16] IHS Inc. Health Workforce Model Documentation, Version 4.4.2016. https://cdn.ihs.com/www/pdf/IHS-HDMM-DocumentationApr2016.pdf. Accessed February 5, 2020.

The model used Texas-specific data when possible and data from national or other sources when necessary. The model presents results for all physicians and 35 physician specialties.

Supply Model

Supply, when used in reference to the physician workforce, refers to the capacity of physicians to provide patient care. In general, the HWSM uses a microsimulation approach that models the likely career choices of individual physicians to project what supply might look like annually through 2032. The HWSM starts with the current supply of physicians, taking into consideration their demographics and practice specialties, and models new physicians entering the workforce, physicians leaving the workforce, and workforce participation patterns as physician demographics change over time. The HWSM reports supply data as a count of the number of FTEs available to provide patient care.

The supply projections presented in this report are based on multiple data sources. Texas physician licensure data are provided by the Texas Medical Board and are geocoded and processed by HPRC at DSHS. The 2015 through 2018 physician files from HPRC were used to model projected new entrants to the Texas physician workforce and physicians leaving the Texas workforce. The 2018 physician file from HPRC was used as the baseline supply for the Texas physician workforce. The baseline year was selected as 2018, as this was the most recent year of physician licensure data available when the projections were generated for this report. Table 1 in Section 4 of this report includes the baseline supply of physicians in Texas.

Additionally, projected medical school enrollment and graduate medical education residency position data provided by the Texas Higher Education Coordinating Board were used to reflect expected growth in new workforce entrants in the near future. Data from Florida, Maryland, New York, and South Carolina were used to estimate the number of hours worked for physicians by specialty, while data from Florida were used to estimate retirement patterns for physicians by specialty. In both cases, reliable and validated data from Texas were unavailable. However, where reliable and validated data from other states were used, patterns were verified to be generalizable.

Demand Model

Demand, as used in this report, is defined as the quantity of physician-provided health care services and care delivery necessary so that Texans, based on their

demographic and health profiles, receive the national average level of care. The HDMM models demand for health care services and providers and includes three major components.

The first component includes characteristics of each person in a representative sample of the current and future population. Characteristics of these individuals include demographics, socioeconomics, health behaviors, and occurrence of chronic conditions among others. Specifically, the HDMM used national and state data from the 2018 American Community Survey, the 2015 Centers for Medicare and Medicaid Services' Minimum Data Set, the 2016 Medicare Current Beneficiary Survey, and the 2014, 2017, and 2018 Behavioral Risk Factor Surveillance System, as well as county population projections from the Texas Demographic Center and county-level demographic counts from the U.S. Census Bureau.

The second component is health care use patterns that relate to patient characteristics. Pooled data from the 2013 through 2017 Medical Expenditure Panel Survey were used to provide a measure of health care services consumed by the average person in the national population.

The third component is national staffing patterns that translate demand for services into the need for FTE physicians by specialty and care delivery setting. To estimate provider staffing ratios for physicians, the HDMM used national data from the 2018 American Medical Association Masterfile.

When demand is greater than supply, a shortage of physician FTEs exists. When supply is greater than demand, a surplus of physician FTEs exists.

Strengths and Limitations

Both the key strengths and limitations of the projections in this report lie in the availability and quality of state-level data.

The main strength of the supply side projections is the use of state-level physician licensure data. These data provide a timely and accurate count of the number of physicians practicing in Texas along with their demographics and practice specialties. Likewise, the use of state-level medical school graduation numbers provides an accurate depiction of the production of new physicians. The main strengths of the demand side projections are the use of state-level population numbers and demographics, which provide a sound starting point for estimating the population's demand for health care services.

As with any model, there are also limitations. On the demand side, baseline projections model the impact of changing demographics over time while health care use and delivery patterns remain the same. The baseline demand projections also assume that disease prevalence and health risk factors will remain consistent by demographic groups over time. As access to care changes, models of care transform, and technology improves health practices and outcomes, it is difficult to predict how health care use and delivery patterns as well as disease prevalence and health risk factors will change over time.

Another limitation is that the demand model assumes that Texas health care utilization is based on national health care use patterns. Without better state-level data on health care use to include in the demand model, it is difficult to know how Texas actually compares to national health care use patterns. Additionally, this assumption does not address the quality of care provided by national use patterns.

4. Supply and Demand Projections for Physicians Statewide

The table below provides the statewide supply and demand projections for all physicians and 35 physician specialties for 2018 and 2032. Supply and demand physician counts are listed as FTEs. Percent of demand met is calculated by dividing supply by demand.[17] A percentage greater than 100 percent indicates a surplus of physician FTEs, while a percentage lower than 100 percent indicates a shortage of physician FTEs.

Table 1. Supply and Demand for Physicians in Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	374	300	124.6%	404	404	100.0%
Anesthesiology	3,750	3,071	122.1%	4,489	4,020	111.7%
Cardiology	1,931	2,173	88.9%	2,311	3,208	72.0%
Colorectal Surgery	161	163	98.9%	233	229	101.9%
Critical Care Medicine	280	335	83.6%	409	467	87.5%
Dermatology	651	700	93.0%	828	922	89.8%
Emergency Medicine	4,716	3,877	121.6%	7,412	4,983	148.7%
Endocrinology	517	709	72.9%	708	982	72.1%

[17] Supply and demand FTEs are rounded to whole numbers. Calculations were made using the unrounded FTE numbers.

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Family Medicine	7,411	8,445	87.8%	9,004	11,499	78.3%
Gastroenterology	1,071	1,080	99.2%	1,355	1,408	96.3%
General Internal Medicine	5,570	7,162	77.8%	7,759	10,366	74.8%
General Surgery	1,593	1,728	92.1%	2,114	2,250	93.9%
Hematology and Oncology	1,131	1,229	92.0%	1,595	1,663	95.9%
Infectious Diseases	450	734	61.3%	660	1,061	62.2%
Neonatology	469	568	82.5%	578	690	83.8%
Nephrology	927	1,196	77.5%	1,319	1,976	66.7%
Neurological Surgery	464	429	108.2%	610	649	94.1%
Neurology	954	984	97.0%	1,215	1,338	90.8%
Obstetrics and Gynecology	3,096	3,424	90.4%	3,783	4,210	89.8%
Ophthalmology	1,198	1,208	99.1%	1,404	1,741	80.6%
Orthopedic Surgery	1,779	1,356	131.2%	2,232	1,727	129.2%
Other Specialties	1,139	2,492	45.7%	1,431	3,330	43.0%
Otolaryngology	663	634	104.6%	772	813	94.9%
Pathology	1,208	1,207	100.1%	1,541	1,683	91.6%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Pediatrics	3,783	5,491	68.9%	4,675	6,588	71.0%
Physical Medicine and Rehabilitation	680	979	69.5%	874	1,405	62.2%
Plastic Surgery	1,019	562	181.2%	1,377	708	194.4%
Psychiatry	2,202	3,263	67.5%	2,852	3,895	73.2%
Pulmonology	748	936	79.9%	1,059	1,300	81.4%
Radiation Oncology	289	421	68.7%	409	569	71.8%
Radiology	2,340	2,018	115.9%	2,984	2,553	116.9%
Rheumatology	340	235	144.5%	457	333	137.4%
Thoracic Surgery	355	327	108.7%	507	449	112.8%
Urology	676	621	108.8%	819	875	93.6%
Vascular Surgery	235	331	71.0%	251	463	54.1%
All Physicians	**54,171**	**60,389**	**89.7%**	**70,431**	**80,761**	**87.2%**

Supply and Demand Projections for All Physicians Statewide

The shortage of physicians is expected to worsen from 2018 to 2032. During this period, the supply of physicians is projected to increase by 30.0 percent, while the demand is projected to increase by 33.7 percent. The supply is projected to increase from 54,171 FTEs in 2018 to 70,431 FTEs in 2032. The demand is projected to increase from 60,389 FTEs in 2018 to 80,761 FTEs in 2032. This deficit of 6,218 FTEs in 2018 is projected to grow to a deficit of 10,330 FTEs in 2032.

Supply and Demand Projections for Physician Specialties Statewide

The specialties of general internal medicine, family medicine, pediatrics, and psychiatry are projected to have the most significant shortages by FTE deficit in 2032.

The specialties with the lowest percentage of demand met by 2032 include vascular surgery (54.1 percent), infectious diseases (62.2 percent), physical medicine and rehabilitation (62.2 percent), and nephrology (66.7 percent).

Notable specialties with projected surpluses by 2032 include: emergency medicine (2,429 FTEs), anesthesiology (469 FTEs), and plastic surgery (669 FTEs).

5. Critical Shortages of Physician Specialties by Region

Critical shortages were defined using a combination of deficit of FTEs and percent of demand met. The exact criteria were set depending on the overall specialty distribution and population of the public health region.[18,19]

Region 1: Panhandle

The Panhandle region has a lower population compared to other public health regions in Texas. The specialties with the greatest shortage deficits by FTE count projected for 2032 were classified as having critical shortages. Critical shortages in the Panhandle include cardiology, nephrology, pediatrics, and psychiatry.

The shortage of cardiologists is projected to grow from a shortage of 15 FTEs in 2018 to 38 FTEs in 2032.

The supply of nephrologists is projected to increase from 20 FTEs to 23 FTEs from 2018 to 2032. In that same timeframe, demand is projected to increase from 43 FTEs to 55 FTEs. In 2018, 46.9 percent of demand was met, and it is projected to be 41.1 percent in 2032.

The supply of pediatricians is expected to grow from 67 FTEs in 2018 to 84 FTEs in 2032, while demand will increase from 152 FTEs in 2018 to 168 FTEs in 2032. In 2018, this is 44.1 percent of demand met, and 50.0 percent in 2032.

Growth in the supply of psychiatrists is projected to be 46.1 percent, from 34 FTEs in 2018 to 50 FTEs in 2032. Demand is projected to increase 3.8 percent, from 96 FTEs to 100 FTEs from 2018 to 2032. This represents 35.5 percent demand met in 2018, and 50.0 percent in 2032.

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[18] The category "Other Specialties" was not included in this section because it is an aggregate category.

[19] Refer to Appendix A for complete supply to demand ratios and FTEs.

Table 2. Critical Shortages of Physician Specialties in Region 1 - Panhandle

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Cardiology	58	73	79.3%	49	87	56.1%
Nephrology	20	43	46.9%	23	55	41.1%
Pediatrics	67	152	44.1%	84	168	50.0%
Psychiatry	34	96	35.5%	50	100	50.0%

Region 2/3: North Texas

The North Texas public health region is one of the most populous public health regions in Texas. Specialties with a shortage of 200 FTEs or more and 70 percent or less of demand met were identified as being in critical shortage. The critical specialty shortages in the North Texas region include cardiology, pediatrics, physical medicine and rehabilitation, and psychiatry.

The shortage of cardiologists is expected to increase from 101 FTEs in 2018 to 382 FTEs by 2032. During that time, the percent of demand met is projected to decrease from 84.2 percent to 61.5 percent.

The shortage of pediatricians is projected to increase from 526 FTEs in 2018 to 733 FTEs in 2032. The percent of demand met is projected to decrease from 67.4 percent to 62.8 percent during the same period.

The demand for physical medicine and rehabilitation physicians will grow much faster than supply between 2018 and 2032. Demand is projected to grow 49.5 percent, while supply is only projected to grow 24.5 percent. This results in a deficit of 132 FTEs in 2018 that grows to 259 FTEs in 2032.

The deficit of psychiatrists was 375 FTEs in 2018 and is projected to be 399 FTEs in 2032. The demand met was 63.6 percent in 2018, and it is projected to be 54.2 percent in 2032.

Table 3. Critical Shortages of Physician Specialties in Region 2/3 - North Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Cardiology	541	643	84.2%	611	993	61.5%
Pediatrics	1,087	1,613	67.4%	1,239	1,972	62.8%
Physical Medicine and Rehabilitation	246	378	65.1%	306	566	54.2%
Psychiatry	654	1,030	63.6%	830	1,229	67.5%

Region 4/5N: East Texas

Critical shortages for East Texas were identified as those having the greatest deficit of FTEs projected for 2032. Critical shortages in East Texas include the specialties of family medicine (123 FTEs), general internal medicine (92 FTEs), nephrology (109 FTEs), pediatrics (80 FTEs), and psychiatry (76 FTEs).

While the shortage of family medicine physicians, general internal medicine specialists, pediatric specialists, and psychiatrists will improve or stay the same between 2018 and 2032, the projected supply of providers will still fail to meet projected demand.

Table 4. Critical Shortages of Physician Specialties in Region 4/5N - East Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Family Medicine	422	571	73.9%	500	622	80.3%
General Internal Medicine	279	400	69.9%	361	453	79.7%
Nephrology	45	133	33.9%	53	163	32.9%
Pediatrics	127	207	61.5%	121	201	60.1%
Psychiatry	80	174	46.1%	92	168	54.8%

Region 6/5S: Gulf Coast

Critical shortages for the Gulf Coast region were classified by a shortage deficit of more than 200 FTEs and a percent of demand met less than 80 percent projected in 2032. Family medicine, general internal medicine, nephrology, and psychiatry are specialties in the Gulf Coast region of Texas that are projected to have critical shortages.

The shortage of family medicine physicians is expected to increase from 315 FTEs in 2018 and 801 FTEs in 2032. During this period, the percent of demand met is projected to decrease from 85.3 percent in 2018 to 74.1 percent in 2032.

The shortage of general internal medicine physicians is also expected to increase. The shortage is projected to increase from 604 FTEs in 2018 to 1,076 FTEs in 2032. The demand met was 70.1 percent in 2018 and is projected to be 65.0 percent in 2032.

The shortage of nephrologists is projected to almost triple from 55 FTEs in 2018 to 217 FTEs in 2032. The percentage of met demand is projected to decrease from 82.5 percent in 2018 to 61.9 percent in 2032.

The shortage of psychiatrists is projected to increase from a deficit of 229 FTEs in 2018 to 242 FTEs in 2032.

Table 5. Critical Shortages of Physician Specialties in Region 6/5S - Gulf Coast

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Family Medicine	1,822	2,137	85.3%	2,289	3,090	74.1%
General Internal Medicine	1,414	2,018	70.1%	1,999	3,075	65.0%
Nephrology	258	313	82.5%	353	571	61.9%
Psychiatry	663	893	74.3%	871	1,113	78.3%

Region 7: Central Texas

Central Texas critical shortages were classified by specialties with a projected deficit greater than 100 FTEs and less than 70 percent of demand met in 2032. In the Central Texas region, cardiology and nephrology are projected to have critical shortages.

The deficit of cardiologists is projected to increase from 37 FTEs in 2018 to 148 FTEs in 2032.

Nephrology is projected to have a deficit of 119 FTEs in 2032 and only 46.7 percent of demand met.

Table 6. Critical Shortages of Physician Specialties in Region 7 - Central Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Cardiology	221	258	85.8%	260	408	63.7%
Nephrology	81	127	63.4%	104	222	46.7%

Region 8: South Texas

In the South Texas region, specialties projected to have a deficit of 100 FTEs or more and less than 80 percent of demand met were classified as critical shortages. In the South Texas region, general internal medicine, pediatrics, and psychiatry are projected to have critical shortages.

The deficit of general internal medicine physicians is projected to increase from 146 FTEs in 2018 to 240 FTEs in 2032.

In absolute terms, the deficit of pediatricians is projected to increase from 175 FTEs to 218 FTEs between 2018 and 2032. In relative terms, the percent of demand met is the same in 2018 and 2032, 68.4 percent.

The shortage of psychiatrists is projected to increase from 70 FTEs in 2018 to 112 FTEs in 2032. The percent of demand met is projected to decrease from 78.5 percent in 2018 to 72.2 percent in 2032.

Table 7. Critical Shortages of Physician Specialties in Region 8 - South Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
General Internal Medicine	579	724	79.9%	775	1,015	76.4%
Pediatrics	379	554	68.4%	471	688	68.4%
Psychiatry	257	327	78.5%	290	402	72.2%

Region 9/10: West Texas

For the West Texas region, critical shortages were identified by the specialties with the greatest projected FTE deficits in 2032. Critical shortages in West Texas include the specialties of family medicine, pediatrics, and psychiatry.

The shortage of family medicine physicians is projected to increase from 185 FTEs to 223 FTEs between 2018 and 2032.

The shortage of pediatricians is projected to increase from a deficit of 137 FTEs in 2018 to 150 FTEs in 2032.

The overall and relative supply of psychiatrists is expected to improve; however, psychiatry is still projected to have the third most significant shortage in 2032. The shortage of psychiatrists in 2018 was 69 FTEs, which was 49.9 percent of demand met. The shortage is projected to be 65 FTEs in 2032 or 60.1 percent of demand met.

Table 8. Critical Shortages of Physician Specialties in Region 9/10 - West Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Family Medicine	275	460	59.8%	364	587	62.0%
Pediatrics	162	298	54.2%	190	340	55.9%
Psychiatry	68	137	49.9%	98	163	60.1%

Region 11: Rio Grande Valley

The criterion for identifying critical shortages in the Rio Grande Valley region was a projected FTE deficit greater than 100. The Rio Grande Valley region is projected to face critical shortages of physicians specializing in anesthesiology, family medicine, pediatrics, and psychiatry.

The shortage of physicians specializing in anesthesiology is projected to increase from 77 FTEs in 2018 to 111 FTEs by 2032.

The shortage of family medicine physicians is projected to increase from 234 FTE to 355 FTEs between 2018 and 2032.

The shortage of pediatricians is expected to continue through 2032. There is a projected deficit of 319 FTEs in 2032, an increase of 31.8 percent from 242 FTEs in 2018.

The shortage of psychiatrists is projected to increase from 126 FTEs in 2018 to 132 FTEs in 2032.

Table 9. Critical Shortages of Physician Specialties in Region 11 - Rio Grande Valley

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	135	212	63.9%	134	245	54.5%
Family Medicine	455	689	66.1%	488	843	57.9%
Pediatrics	268	510	52.6%	205	523	39.1%
Psychiatry	73	199	36.7%	82	214	38.5%

6. Conclusion

This report presents the supply and demand projections for all physicians and 35 physician specialties statewide from 2018 through 2032. This report also identifies critical shortages of physician specialties by public health region.

Statewide results indicate that demand is projected to exceed supply for all physicians and 22 of 35 physician specialties from 2018 through 2032 (see Table 1 in Section 4). The shortage of all physicians and 19 physician specialties is projected to worsen between 2018 and 2032. Moreover, four physician specialties are projected to worsen from a surplus in 2018 to a shortage by 2032. Only one physician specialty is projected to improve from a shortage in 2018 to a surplus by 2032.

Results indicate that physician specialties identified as critical shortages vary by region. Psychiatry is identified as a critical shortage in all regions of the state except Central Texas (Region 7). Pediatrics is identified as a critical shortage in all regions of the state except the Gulf Coast (Region 6/5S) and Central Texas. Family medicine is identified as a critical shortage in all regions of the state except the Panhandle (Region 1), North Texas (Region 2/3), Central Texas, and South Texas (Region 8).

Results from this report indicate that there is a current shortage of physicians in Texas that will increase through 2032. Current projections in medical school enrollment and resident positions by the Texas Higher Education Coordinating Board indicate that the state's graduate medical education system will not create a supply of physicians that can meet projected demand.

Unless corrective measures are taken, the shortage of physicians in Texas may persist beyond 2032. As the legislature continues to analyze the shortage of physicians in the state, DSHS will continue to work with stakeholders to ensure accurate and consistent understanding of the shortages facing Texas today and in the future.

List of Acronyms

Acronym	Full Name
DSHS	Texas Department of State Health Services
FTE	Full-time equivalent
HDMM	Healthcare Demand Microsimulation Model
HPRC	Health Professions Resource Center
HWSM	Health Workforce Supply Model

Appendix A. Supply and Demand Projections for Physician Specialties by Region[20]

Table 10. Physician Specialties with a Projected Shortage by 2032 in Region 1 - Panhandle

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Cardiology	58	73	79.3%	49	87	56.1%
Colorectal Surgery	1	5	18.1%	0	6	0.3%
Critical Care Medicine	4	11	34.6%	6	13	43.7%
Dermatology	15	19	81.3%	18	21	88.0%
Endocrinology	12	17	68.0%	6	20	31.8%
Family Medicine	239	285	84.1%	301	331	91.1%
Gastroenterology	34	34	101.9%	30	38	79.8%
Hematology and Oncology	22	37	59.1%	29	43	68.7%
Infectious Diseases	6	24	26.4%	7	29	25.2%
Nephrology	20	43	46.9%	23	55	41.1%
Obstetrics and Gynecology	87	104	83.5%	113	117	96.8%

[20] Tables in this section are determined by whether a physician specialty is projected to have a shortage or surplus in 2032.

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Ophthalmology	36	39	94.1%	35	46	75.7%
Other Specialties	36	76	47.6%	70	86	80.8%
Pathology	28	40	71.5%	37	47	77.8%
Pediatrics	67	152	44.1%	84	168	50.0%
Physical Medicine and Rehabilitation	8	9	88.6%	3	9	32.9%
Psychiatry	34	96	35.5%	50	100	50.0%
Pulmonology	15	29	51.6%	22	34	65.5%
Radiation Oncology	9	13	71.6%	2	15	11.0%
Thoracic Surgery	8	11	79.3%	11	12	90.1%
Urology	25	22	112.8%	21	27	80.1%
Vascular Surgery	5	11	45.8%	10	13	78.4%

Table 11. Physician Specialties with a Projected Surplus by 2032 in Region 1 – Panhandle

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	9	7	129.1%	11	8	144.3%
Anesthesiology	100	97	103.2%	124	109	113.9%
Emergency Medicine	134	126	106.0%	172	142	120.5%
General Internal Medicine	142	209	67.7%	255	249	102.4%
General Surgery	53	60	88.0%	84	66	127.3%
Neonatology	14	15	90.0%	38	17	216.5%
Neurological Surgery	16	10	166.6%	22	11	198.8%
Neurology	21	32	67.1%	38	36	103.8%
Orthopedic Surgery	62	41	152.5%	72	44	165.1%
Otolaryngology	17	20	82.6%	33	22	150.5%
Plastic Surgery	16	19	86.6%	21	20	107.7%
Radiology	80	52	155.5%	85	53	158.7%
Rheumatology	10	6	179.4%	15	7	227.6%

Table 12. Physician Specialties with a Projected Shortage by 2032 in Region 2/3 – North Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	118	97	121.6%	110	136	80.9%
Cardiology	541	643	84.2%	611	993	61.5%
Critical Care Medicine	61	96	64.1%	76	139	54.5%
Dermatology	206	237	87.0%	252	317	79.5%
Endocrinology	150	207	72.7%	206	291	70.9%
Family Medicine	2,219	2,391	92.8%	2,640	3,351	78.8%
General Internal Medicine	1,913	2,209	86.6%	2,564	3,307	77.5%
Hematology and Oncology	284	363	78.2%	376	510	73.8%
Infectious Diseases	155	206	75.4%	247	309	80.0%
Neonatology	139	166	83.7%	154	213	72.3%
Nephrology	299	289	103.4%	484	524	92.4%
Neurological Surgery	146	143	102.5%	185	223	82.9%
Neurology	292	296	98.6%	344	415	83.0%
Obstetrics and Gynecology	951	1,018	93.5%	1,074	1,286	83.6%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Ophthalmology	331	350	94.7%	359	523	68.7%
Other Specialties	351	746	47.0%	427	1,024	41.7%
Otolaryngology	194	194	99.8%	202	253	79.6%
Pathology	382	344	110.8%	497	502	99.1%
Pediatrics	1,087	1,613	67.4%	1,239	1,972	62.8%
Physical Medicine and Rehabilitation	246	378	65.1%	306	566	54.2%
Psychiatry	654	1,030	63.6%	830	1,229	67.5%
Pulmonology	223	275	81.2%	308	395	77.9%
Radiation Oncology	77	124	61.7%	110	175	62.9%
Thoracic Surgery	102	96	106.1%	125	137	90.7%
Urology	192	174	110.0%	219	254	86.5%
Vascular Surgery	75	96	78.0%	79	140	56.3%

Table 13. Physician Specialties with a Projected Surplus by 2032 in Region 2/3 – North Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	1,338	913	146.4%	1,487	1,227	121.1%
Colorectal Surgery	61	47	129.2%	83	69	120.2%
Emergency Medicine	1,415	1,108	127.7%	2,089	1,463	142.8%
Gastroenterology	351	323	108.4%	451	429	105.0%
General Surgery	531	489	108.6%	676	651	103.8%
Orthopedic Surgery	635	420	151.0%	755	543	139.1%
Plastic Surgery	331	180	183.6%	431	231	187.0%
Radiology	771	689	112.0%	1,016	883	115.1%
Rheumatology	106	67	157.3%	130	99	130.9%

Table 14. Physician Specialties with a Projected Shortage by 2032 in Region 4/5N – East Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	128	190	67.4%	148	202	73.1%
Cardiology	99	146	68.1%	109	167	64.8%
Colorectal Surgery	1	11	11.4%	0	12	0.4%
Critical Care Medicine	9	23	40.8%	23	25	89.9%
Dermatology	21	36	58.2%	14	38	36.4%
Endocrinology	19	40	48.7%	24	44	54.5%
Family Medicine	422	571	73.9%	500	622	80.3%
Gastroenterology	52	59	89.0%	54	62	87.7%
General Internal Medicine	279	400	69.9%	361	453	79.7%
General Surgery	84	139	60.0%	94	147	64.0%
Hematology and Oncology	41	70	57.9%	51	77	66.4%
Infectious Diseases	11	46	23.6%	15	52	28.9%
Neonatology	16	25	62.7%	21	24	88.0%
Nephrology	45	133	33.9%	53	163	32.9%
Neurological Surgery	20	20	100.2%	12	22	55.5%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Neurology	42	54	79.0%	43	58	74.5%
Obstetrics and Gynecology	132	167	78.9%	145	168	86.0%
Ophthalmology	63	80	77.8%	81	92	88.4%
Orthopedic Surgery	97	86	112.8%	87	88	98.5%
Other Specialties	54	149	36.2%	39	160	24.3%
Otolaryngology	28	42	67.6%	19	43	43.2%
Pathology	43	82	52.2%	46	91	51.0%
Pediatrics	127	207	61.5%	121	201	60.1%
Physical Medicine and Rehabilitation	37	34	106.1%	33	37	90.3%
Plastic Surgery	25	32	75.9%	23	34	66.1%
Psychiatry	80	174	46.1%	92	168	54.8%
Pulmonology	44	58	75.5%	52	64	80.9%
Radiation Oncology	11	24	46.1%	13	26	51.1%
Radiology	103	123	83.5%	95	128	74.7%
Urology	43	42	103.2%	38	48	79.8%
Vascular Surgery	16	29	55.8%	6	32	18.6%

Table 15. Physician Specialties with a Projected Surplus by 2032 in Region 4/5N – East Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	14	13	101.2%	21	14	148.3%
Emergency Medicine	281	246	114.3%	409	257	159.2%
Rheumatology	15	12	126.6%	16	13	121.2%
Thoracic Surgery	23	19	120.9%	22	21	103.6%

Table 16. Physician Specialties with a Projected Shortage by 2032 in Region 6/5S – Gulf Coast

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Cardiology	601	588	102.2%	783	924	84.8%
Endocrinology	180	196	91.6%	276	288	96.0%
Family Medicine	1,822	2,137	85.3%	2,289	3,090	74.1%
Gastroenterology	306	288	106.2%	388	392	99.1%
General Internal Medicine	1,414	2,018	70.1%	1,999	3,075	65.0%
Infectious Diseases	161	196	81.9%	197	301	65.5%
Nephrology	258	313	82.5%	353	571	61.9%
Ophthalmology	325	312	104.0%	382	478	80.0%
Other Specialties	345	670	51.5%	487	943	51.7%
Pediatrics	1,169	1,525	76.6%	1,682	1,925	87.4%
Physical Medicine and Rehabilitation	194	324	59.7%	278	458	60.7%
Psychiatry	663	893	74.3%	871	1,113	78.3%
Vascular Surgery	47	85	55.3%	54	127	42.6%

Table 17. Physician Specialties with a Projected Surplus by 2032 in Region 6/5S – Gulf Coast

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	105	95	110.5%	155	129	120.0%
Anesthesiology	1,062	802	132.4%	1,397	1,108	126.1%
Colorectal Surgery	52	42	123.8%	101	62	162.6%
Critical Care Medicine	109	89	123.0%	161	132	122.0%
Dermatology	192	189	102.0%	277	257	107.5%
Emergency Medicine	1,220	1,018	119.9%	1,881	1,378	136.6%
General Surgery	396	425	93.2%	606	589	102.8%
Hematology and Oncology	497	329	150.9%	748	464	161.1%
Neonatology	143	160	89.5%	210	203	103.5%
Neurological Surgery	146	135	108.0%	216	213	101.6%
Neurology	310	277	111.7%	412	395	104.2%
Obstetrics and Gynecology	893	900	99.3%	1,169	1,163	100.5%
Orthopedic Surgery	426	364	117.0%	558	486	114.9%
Otolaryngology	208	162	128.2%	301	220	136.6%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Pathology	425	321	132.6%	621	475	130.7%
Plastic Surgery	326	147	221.9%	434	192	225.4%
Pulmonology	234	253	92.1%	373	369	100.9%
Radiation Oncology	130	113	115.6%	200	159	125.7%
Radiology	687	546	125.9%	889	715	124.5%
Rheumatology	103	68	151.0%	146	101	144.5%
Thoracic Surgery	117	88	132.8%	202	128	158.6%
Urology	194	156	124.4%	246	233	105.9%

Table 18. Physician Specialties with a Projected Shortage by 2032 in Region 7 – Central Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	414	396	104.5%	482	542	88.9%
Cardiology	221	258	85.8%	260	408	63.7%
Colorectal Surgery	14	20	72.3%	15	30	50.1%
Critical Care Medicine	24	40	59.7%	31	59	53.0%
Endocrinology	52	83	62.8%	57	124	45.9%
Family Medicine	1,139	1,019	111.7%	1,445	1,467	98.5%
Gastroenterology	131	136	96.5%	167	189	88.6%
General Internal Medicine	721	867	83.1%	1,127	1,335	84.4%
General Surgery	201	224	89.9%	242	310	77.9%
Hematology and Oncology	98	149	65.8%	142	218	65.0%
Infectious Diseases	39	88	44.1%	70	137	51.1%
Neonatology	58	64	90.1%	52	78	66.6%
Nephrology	81	127	63.4%	104	222	46.7%
Neurological Surgery	58	45	127.6%	63	76	82.3%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Obstetrics and Gynecology	391	466	83.9%	519	580	89.5%
Other Specialties	150	303	49.4%	180	427	42.3%
Otolaryngology	101	84	120.7%	101	113	89.6%
Pathology	123	144	85.5%	126	212	59.4%
Pediatrics	525	632	83.0%	684	770	88.8%
Physical Medicine and Rehabilitation	82	84	97.3%	100	134	74.3%
Pulmonology	89	112	79.6%	121	167	72.3%
Radiation Oncology	32	51	62.0%	46	75	61.7%
Radiology	268	264	101.5%	359	364	98.6%
Thoracic Surgery	37	40	90.4%	57	59	96.1%
Vascular Surgery	24	40	60.7%	26	60	43.1%

Table 19. Physician Specialties with a Projected Surplus by 2032 in Region 7 – Central Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	61	31	198.4%	49	43	112.5%
Dermatology	105	93	113.3%	146	131	111.3%
Emergency Medicine	700	466	150.3%	1,193	623	191.6%
Neurology	138	119	116.0%	200	171	116.9%
Ophthalmology	176	148	119.3%	237	227	104.5%
Orthopedic Surgery	231	167	137.8%	335	227	147.4%
Plastic Surgery	159	76	210.1%	238	102	233.8%
Psychiatry	372	407	91.2%	539	507	106.3%
Rheumatology	39	24	166.3%	70	37	190.9%
Urology	86	80	107.4%	123	120	102.7%

Table 20. Physician Specialties with a Projected Shortage by 2032 in Region 8 – South Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	41	31	133.3%	34	42	82.3%
Cardiology	216	224	96.6%	270	317	85.2%
Colorectal Surgery	18	18	104.1%	21	24	84.7%
Dermatology	72	71	101.1%	72	92	77.9%
Endocrinology	59	78	76.6%	69	105	65.7%
Family Medicine	841	894	94.0%	977	1,208	80.9%
Gastroenterology	103	108	95.3%	139	140	99.6%
General Internal Medicine	579	724	79.9%	775	1,015	76.4%
General Surgery	171	177	96.3%	200	230	87.1%
Hematology and Oncology	108	121	88.9%	151	162	93.1%
Infectious Diseases	37	76	49.4%	63	106	59.2%
Neonatology	43	56	76.8%	65	68	94.5%
Nephrology	120	129	92.9%	161	205	78.2%
Neurological Surgery	36	48	75.8%	60	69	87.6%
Neurology	86	96	88.9%	118	130	90.9%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Obstetrics and Gynecology	305	342	89.2%	370	425	87.1%
Ophthalmology	144	128	112.3%	175	180	97.1%
Other Specialties	122	254	47.9%	153	337	45.4%
Otolaryngology	63	62	101.4%	67	80	83.7%
Pathology	120	122	98.3%	151	167	90.7%
Pediatrics	379	554	68.4%	471	688	68.4%
Physical Medicine and Rehabilitation	78	127	61.0%	112	175	63.8%
Psychiatry	257	327	78.5%	290	402	72.2%
Pulmonology	65	95	68.3%	83	129	63.9%
Radiation Oncology	15	41	35.9%	23	56	42.2%

Table 21. Physician Specialties with a Projected Surplus by 2032 in Region 8 – South Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	462	311	148.5%	583	405	144.0%
Critical Care Medicine	35	34	102.8%	49	46	105.4%
Emergency Medicine	491	396	123.8%	784	515	152.3%
Orthopedic Surgery	178	134	132.6%	234	171	136.5%
Plastic Surgery	98	54	181.8%	145	67	216.3%
Radiology	222	201	110.2%	286	248	115.2%
Rheumatology	40	26	155.0%	39	35	109.1%
Thoracic Surgery	33	32	104.4%	57	43	133.7%
Urology	73	63	114.8%	99	87	113.0%
Vascular Surgery	36	34	107.1%	51	46	111.0%

Table 22. Physician Specialties with a Projected Shortage by 2032 in Region 9/10 – West Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Anesthesiology	110	149	74.1%	134	181	74.0%
Colorectal Surgery	5	8	57.5%	10	11	95.5%
Endocrinology	14	33	43.6%	24	41	57.2%
Family Medicine	275	460	59.8%	364	587	62.0%
General Internal Medicine	249	294	84.5%	356	379	93.9%
Hematology and Oncology	37	63	58.2%	40	78	52.1%
Infectious Diseases	16	40	41.3%	27	52	52.6%
Neonatology	21	31	67.8%	22	35	62.1%
Nephrology	39	69	56.5%	61	100	60.9%
Neurology	22	44	50.0%	19	55	34.0%
Obstetrics and Gynecology	149	176	84.8%	188	204	92.2%
Other Specialties	30	119	25.3%	30	147	20.1%
Otolaryngology	23	31	75.5%	23	37	62.5%
Pathology	39	62	62.4%	34	78	43.6%
Pediatrics	162	298	54.2%	190	340	55.9%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Psychiatry	68	137	49.9%	98	163	60.1%
Pulmonology	26	46	56.3%	38	59	65.1%
Radiation Oncology	5	22	22.2%	5	27	20.1%
Rheumatology	10	13	75.5%	17	17	97.2%
Thoracic Surgery	16	16	101.2%	9	20	45.0%
Urology	30	33	90.6%	30	43	70.6%
Vascular Surgery	14	16	88.5%	14	20	68.7%

Table 23. Physician Specialties with a Projected Surplus by 2032 in Region 9/10 – West Texas

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	12	10	116.2%	13	13	101.4%
Cardiology	82	99	82.5%	133	129	103.3%
Critical Care Medicine	13	17	75.3%	22	22	102.0%
Dermatology	25	24	103.4%	30	29	105.2%
Emergency Medicine	216	208	104.2%	453	256	177.3%
Gastroenterology	47	53	87.6%	72	65	111.3%
General Surgery	73	90	81.1%	121	111	109.8%
Neurological Surgery	16	10	160.5%	23	13	174.9%
Ophthalmology	50	59	85.6%	76	76	100.3%
Orthopedic Surgery	76	61	124.5%	108	75	145.0%
Physical Medicine and Rehabilitation	20	8	259.0%	28	10	275.4%
Plastic Surgery	39	24	159.2%	58	29	202.3%
Radiology	99	68	144.8%	140	78	178.5%

Table 24. Physician Specialties with a Projected Shortage by 2032 in Region 11 – Rio Grande Valley

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Allergy and Immunology	15	16	92.2%	10	18	54.0%
Anesthesiology	135	212	63.9%	134	245	54.5%
Cardiology	113	143	78.9%	96	183	52.3%
Colorectal Surgery	9	12	70.3%	4	16	25.7%
Dermatology	14	32	45.6%	19	36	52.6%
Endocrinology	30	55	53.6%	46	69	66.4%
Family Medicine	455	689	66.1%	488	843	57.9%
Gastroenterology	48	80	59.8%	53	94	56.8%
General Internal Medicine	274	440	62.1%	321	552	58.2%
General Surgery	84	124	68.0%	91	146	62.1%
Hematology and Oncology	46	97	47.3%	58	112	51.9%
Infectious Diseases	25	60	41.6%	33	76	43.9%
Neonatology	35	50	70.0%	18	52	33.8%
Nephrology	65	93	70.1%	80	137	58.6%
Neurology	43	65	65.3%	42	78	53.5%

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Obstetrics and Gynecology	187	251	74.7%	205	268	76.6%
Ophthalmology	72	92	78.2%	57	118	48.5%
Orthopedic Surgery	74	82	90.5%	83	94	88.8%
Other Specialties	51	175	29.2%	45	205	21.8%
Otolaryngology	30	40	74.8%	27	45	60.4%
Pathology	48	92	52.5%	30	112	26.3%
Pediatrics	268	510	52.6%	205	523	39.1%
Physical Medicine and Rehabilitation	16	13	117.9%	13	16	86.5%
Plastic Surgery	26	30	85.9%	27	34	80.9%
Psychiatry	73	199	36.7%	82	214	38.5%
Pulmonology	52	67	77.8%	62	83	75.1%
Radiation Oncology	11	33	32.2%	9	38	24.1%
Thoracic Surgery	18	24	75.6%	24	29	81.5%
Urology	33	51	66.3%	42	64	65.3%
Vascular Surgery	18	21	85.6%	11	26	43.7%

Table 25. Physician Specialties with a Projected Surplus by 2032 in Region 11 – Rio Grande Valley

Specialty	2018 Supply (FTEs)	2018 Demand (FTEs)	2018 Percent Demand Met	2032 Supply (FTEs)	2032 Demand (FTEs)	2032 Percent Demand Met
Critical Care Medicine	25	26	96.5%	42	31	134.1%
Emergency Medicine	259	310	83.6%	430	349	123.2%
Neurological Surgery	25	18	140.0%	30	22	135.0%
Radiology	110	76	145.0%	114	84	135.5%
Rheumatology	16	19	84.5%	24	23	104.7%

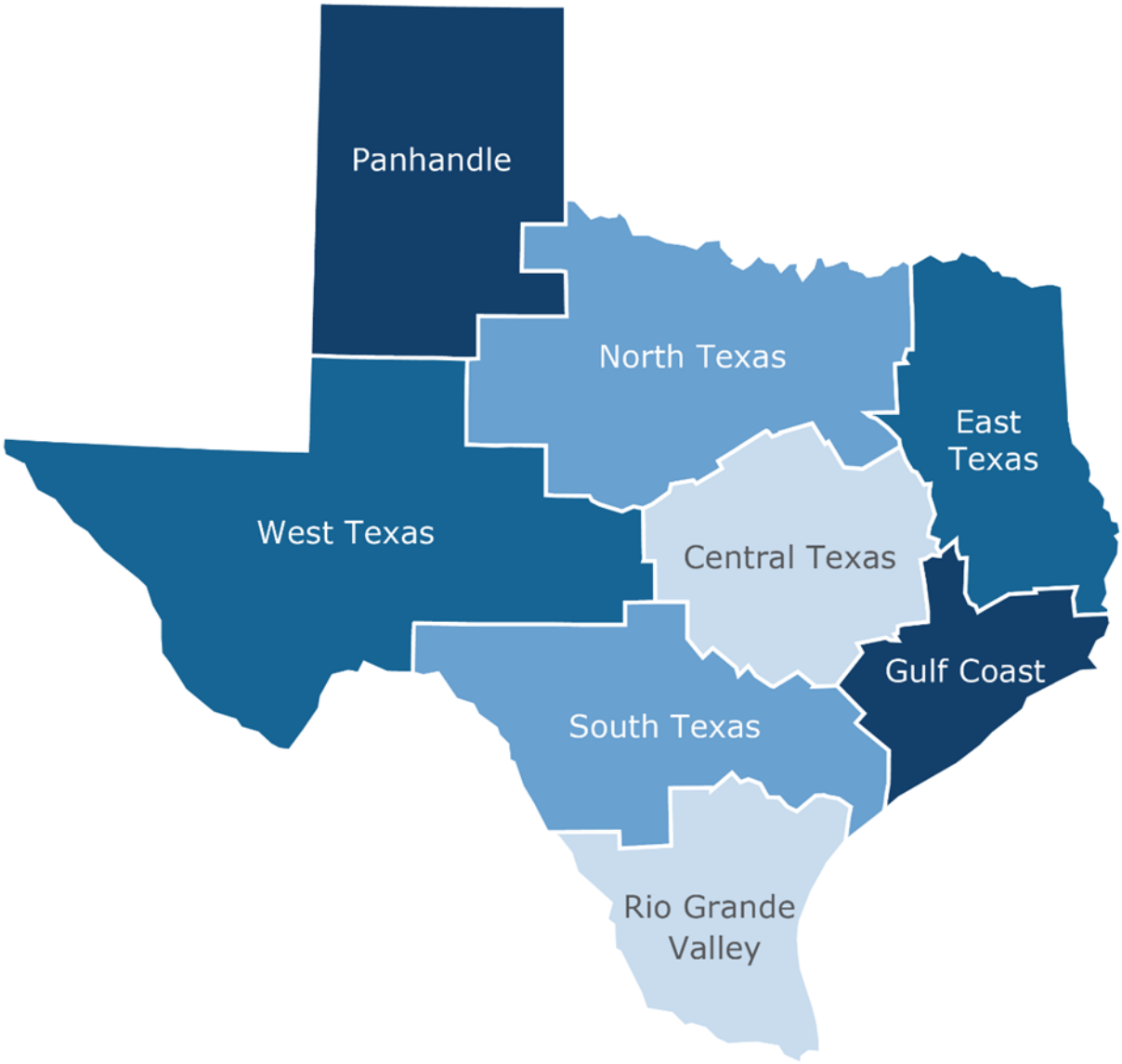
Appendix B. Texas Health Data

Texas Health Data is an interactive public data system that allows users to query DSHS public health datasets for statistical reports and summaries. The public may view through tables and figures the statewide and regional supply and demand projections for all physicians and 35 physician specialties from 2018 through 2032 by visiting the following webpage on Texas Health Data: http://healthdata.dshs.texas.gov/WorkforceSupplyAndDemandProjections.

Appendix C. Texas Public Health Regions

The map below of Texas' eight public health regions includes the regional names used in this report. The public may view which region each Texas county is located by visiting the following webpage on the DSHS website: https://www.dshs.texas.gov/chs/info/info_txco.shtm.

Figure 1. Map of Texas Regions



UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

Press Briefing by Press Secretary Jen Psaki, The White House (July 23, 2021)

EXHIBIT A-6

BRIEFING ROOM

Press Briefing by Press Secretary Jen Psaki, July 23, 2021

JULY 23, 2021 • PRESS BRIEFINGS

James S. Brady Press Briefing Room

1:14 P.M. EDT

MS. PSAKI: Hi everyone. Happy Friday. Okay, a couple of notes for you at the top.

Today, the Biden-Harris administration took additional steps to provide stability and relief to homeowners who are still feeling the economic effects of the COVID-19 pandemic.

HUD, USDA, and the VA announced details to help people with government-backed mortgages stay in their homes through monthly payment reductions and potential loan modifications.

Homeowners could see reductions in their monthly payments of roughly 20 to 25 percent, allowing them to remain in their homes and build long-term equity.

We're working hard to get the word out to Americans who may benefit from these new programs. And thanks to the work of the Consumer Financial Protection Bureau and today's actions, most servicers of mortgages are required to provide borrowers information about these options.

Homeowners can visit ConsumerFinance.gov/Housing for up-to-date information and more details.

Also would note, on our delegation in Haiti, the presidential delegation is safe and accounted for in light of the reported shootings outside of the funeral. They're on their way back to the United States.

We are deeply concerned about unrest in Haiti. In this critical moment, Haiti's leaders must come together to chart a united path that reflects the will of the Haitian people.

We remain committed to supporting the people of Haiti in this challenging time.

Also, a vaccine-sharing update for you: We shipped a record number of doses to a record number of countries this week. Twenty-two million doses went out to 23 countries, including Guatemala, Senegal, Zambia, Niger, Gambia, El Salvador, Honduras, the Central African Republic, Cameroon, Lesotho, Panama, Vietnam, Georgia, Pakistan, Tanzania, Mozambique, Benin, Morocco, Tajikistan, Colombia, Madagascar, Liberia, and Eswatini.

Our teams across the government are working to get more and more doses out every day, but this was a record week for our efforts to provide supply to the global community.

Finally, week ahead: On Monday, the President will host an event in the Rose Garden to celebrate the 31st anniversary of the Americans with Disabilities Act, which the President proudly cosponsored as a senator. While we have much work to do to realize the full aspiration of the ADA, our country has made progress toward its goals of equality of opportunity, full participation, self-sufficiency, and respect for the 61 million Americans with disabilities.

Also Monday, the President will welcome Prime Min- — the Prime Minister of Iraq to the White House. The Prime Minister's visit will highlight the strategic partnership between the United States and Iraq, and advance bilateral cooperation under a Strategic — the Strategic Framework Agreement.

The visit will also focus on key areas of shared interest, including through education, health, cultural, economic, energy, and climate initiatives. President Biden looks forward to strengthening bilateral cooperation with Iraq on political, economic, and security issues, including joint efforts to ensure the enduring defeat of ISIS.

On Wednesday, the President will travel to Pennsylvania and Lehigh Valley — in the Lehigh Valley area, where he will emphasize the importance of American manufacturing, buying products made in America, and supporting good-paying jobs for American workers.

We'll have more details for you over the weekend as things get finalized.

Josh, why don't you kick us off.

Q Thanks, Jen. Two subject areas. First, an AP-NORC survey found that 45 percent of the unvaccinated say they would definitely not get vaccinated. Another 35 percent say they probably won't get vaccinated. Why does this opposition still exist after all the public

outreach? And should more governments and employers mandate vaccinations?

MS. PSAKI: Well, Josh, I think — let's take a step back first. In December, before the President took office, the percentage of Americans willing to get a shot was in the 30s. Today, over 68 percent of adult Americans have taken a shot.

So, what that shows you is that, in a relatively short period of time, we've been able to influence a whole lot of people to change their minds, taken ac- — take action, get a shot, save their lives and the lives of people around them.

I'd also note that we've seen some encouraging data over the last couple of weeks. The five states with the highest case rates — Arkansas, Florida, Louisiana, Missouri, and Nevada — had a higher rate of people getting newly vaccinated compared to the national average. That is a good sign. This is the second week in a row — I noted this last week.

And finally, in the past 10 days, more than 5.2 million Americans have gotten a shot.

Now, there will be institutions, there will be private-sector companies, and others who make decisions about how to keep their communities safe. That's certainly appropriate, but I would just note that we're going to continue our efforts to go community by community, case by case to convey the accurate information about the efficacy of vaccines.

Q Gotcha. Secondly, the Taliban has said that, as a condition for peace in Afghanistan, Ashraf Ghani has to be removed as President and a new negotiated government formed. Does the administration believe that that's in the best interest of the Afghan people and U.S. national security?

MS. PSAKI: Well, first, the President and the administration supports the leadership of the Afghan people, including Ashraf Ghani. The President was scheduled to speak with him today, I believe, and I don't believe there's a readout that's come out about that call quite yet. It may while we're speaking here.

I would note that there are ongoing political negotiations and discussions that we certainly support between Afghan leaders, members of the Afghan government, and the Taliban. And we believe a political solution is the only outcome to lasting peace in Afghanistan, but we will continue to provide support to the government in the form of humanitarian support, security support, training. And we'll also continue to encourage them to take a leading role in defending and protecting their own people.

Go ahead.

Q Thanks, Jen. Alabama's Republican governor says it is "time to start blaming the unvaccinated folks" who "are letting us down." What do you think about that take? Should the administration be taking a sharper tone against unvaccinated people for putting vaccinated people at risk?

MS. PSAKI: Well, I don't think our role is to place blame, but what we can do is provide accurate information to people who are not yet vaccinated about the risks they are incurring not only among — on themselves, but also the people around them.

And while, if you are a young person, you may think you're Superman or Superwoman and immune from the — from getting the virus, that is not true. That is not accurate. You can get very sick. You can die from the virus. You can also make your grandparents sick and your parents sick. That is factual information.

We're not — but we're not here to place blame or threats; we're here to provide accurate information.

Q She says that she doesn't know what else she can do at this point, that she's hit a brick wall with trying to convince people to get vaccinated. Is that a sign that perhaps the federal government should step in and issue mandates? And if not, are you putting the needs of unvaccinated people ahead of the needs of vaccinated people?

MS. PSAKI: Well, I think the question here — one, that's not the role of the federal government; that is the role that institutions, private-sector entities, and others may take. That certainly is appropriate. Also, local communities are going to take steps they need to take in order to protect people in their communities.

I will say: We understand her frustration, and we understand the frustration of leaders out there and public voices who are trying to say the right thing, advocate for the efficacy of the virus, save people in their communities.

What our role is and what we are going to continue to do is make the vaccine available. We're going to continue to work in partnership to fight misinformation. And we're going to continue to advocate and work in partnership with local officials and — and trusted voices to get the word out.

Q And is there something to be learned from our neighbors to the north — Canada? They got

a much slower start. They didn't have nearly as many vaccines as we did early on. And yet, now they've shot past us, and 70 percent of their population is at least partially vaccinated. What's the difference between the two countries? What can we learn from their experience?

MS. PSAKI: Well, first, I would say 162 million Americans are now vaccinated. That certainly is a positive step. We're the first to say and we have long said that that's not enough. We need to ensure more people and more communities are vaccinated. And it is now — we reached a point where there are some communities, even states, where there are 70 percent, 80 percent, or higher vaccination rates.

Other communities where there's 40 percent, 50 percent, or otherwise, that's not just a health issue — it's a huge health issue — it's an economic issue. We've seen how that can impact local communities, as it may lead to shutdowns of different businesses. That can have — it's an economic issue as well.

So, of course, we work in close partnership with our neighbors, but we have 162 million Americans vaccinated. We're the world's largest provider of vaccines to the global community. That's progress, in our view, even as we've said from the beginning there's more work to be done.

Go ahead.

Q Thank you. About the economics of COVID that you just mentioned: Now that daily doses administered of the vaccine are down below 300,000 for the first time since December, we've heard talk about maybe updating the mask guidance. Do you know if there's been any talk here about updating guidance to start shutting businesses down in places that have very low vaccination rates?

MS. PSAKI: No. There has not been, no.

Q Okay. And then on crime, generally —

MS. PSAKI: Can I note, though, two things —

Q Yeah.

MS. PSAKI: — just for your public information purposes? One is that, while we have seen — while we don't look at one week of data as an indication of — as you know, we talk about weekly averages — we did see larger numbers of unemployment claims in areas where there

are lower vaccination rates. We — it's not enough data to draw a conclusion; I'm just noting it for all of you.

I would also note that, on the American Rescue Plan, the way we designed that is for the impact and the assistance that we're providing to communities across the country to be long-lasting — not to stop all in July or all in September. It extends far beyond. It was — that is a lesson learned from the past. And so, there are different components of that package that's providing assistance to businesses, to organizations, to communities that is going to be lasting for months to come.

Q Okay.

MS. PSAKI: Proceed.

Q And then, on crime: The intersection in D.C. that was shot up last night, only about a mile and a half from here, President Biden had lunch in that neighborhood this summer. What is your message to innocent people who live in cities like this one who might start to get worried about getting caught in the crossfire?

MS. PSAKI: Well, I — the message is that the cornerstone of the President's comprehensive plan to reduce gun violence is providing communities with the tools and resources they need to reduce gun crime, including in Washington, D.C.

And there are a couple of steps specific to Washington D.C. I mean, a lot of us live there or live in the neighboring communities, or know people who are on 14th street or in the neighboring areas. And for people who are not — who are watching or hearing this who are not from those neighborhoods, there's a lot of restaurants there, a lot of foot traffic. This is a pretty popular part of — of the city many of us live in.

It's one of — D.C. is one of the five areas nationwide where DOJ launched gun trafficking strike forces just yesterday, which are going to for- — focus law enforcement resources across jurisdictions to keep guns out of the hands of criminals.

D.C. is also a part of our 16 City Community Violence Intervention Collaborative, which is helping cities implement evidence-based strategies and which have been shown to reduce violence by as much as 60 percent.

And Washington D.C. is also taking advantage of the historic funding that they've gotten through the Rescue Plan to bolster public safety. So, Mayor Bowser's budget proposal would

invest $59 million from the Rescue Plan to reduce violent crime. It would add 100 new slots to the cadet program and add $14 million for youth safety initiatives.

So we're certainly seeing this and feeling this, even in our community here, and it is one of the cities that DOJ is focused on.

Q And you just mentioned the White House is working with D.C. as part of this collaborative. But just in the last week and a half or so since the mayor of D.C. was here, a six-year-old girl was shot and killed, a Nationals game had to be evacuated, and then there's this incident last night where diners are diving for cover. So, at what point would the President maybe reconsider his strategy?

MS. PSAKI: Well, I would say we're just implementing our strategy, which is a multi-pronged effort to work in partnership with local leaders — including Mayor Bowser, who has been a great partner to us in this effort — to address gun violence that's rising in cities across the country, including Washington. And the events of the last week are just examples of that.

Go ahead.

Q Thanks, Jen. Secretary Yellen just said, before you came to the podium, that the Treasury Department will need to take extraordinary measures if the debt limit isn't raised by August. And she indicated those could run out shortly after lawmakers return, possibly as soon as October. So, does the White House — are you guys setting a deadline? Before recess, do you want to see that debt limit raised? And what is the White House doing to urge lawmakers to address the debt limit?

MS. PSAKI: This is like the Olympics for Bloomberg, these days. (Laughter.) So, I would say —

Q And Reuters.

MS. PSAKI: And Reuters, sorry. And other financial outlets in the room.

Let me give you just a little bit of context, for those of you who have not seen the letter that just went from Secretary Yellen to the Hill.

So, this is a letter that's standard practice for Treasury Secretaries when a debt limit is going to be reimposed, which there's a timeline coming up at the end of this month. That is diff- — I'm not saying you're suggesting this — that is different from defaulting, which has never happened in the history of the United States and would clearly be a catastrophic event. But it is a

timeline for the debt limit to be — to be raised or extended.

So, during the previous two administrations, the Treasury Secretary sent nearly 50 letters to the Hill on the debt limit, some of which were very similar in wording and asks and updates to this letter. And raising or suspending the debt limit does not authorize new spending commitments; it simply enables the government to pay for obligations that Congresses and Presidents of both parties have already approved.

And Congress — finally the last piece of history — has raised or suspended the debt limit approximately 80 times, which has happened under both Republican and Democratic Presidents — I will say, just for historical fact, more often under Republican Presidents.

But it has happened under both, and it has been supported in a bipartisan way. So, we expect Congress to act promptly to raise or suspend the debt limit and protect the full faith and credit of the United States.

Now, it is not — I gave you all the context because it is not out of the ordinary, even though they're called "extraordinary measures," for Treasury Secretaries to present to Capitol Hill steps that they are going to take, even as this is being litigated on Capitol Hill. That was the — this is what — that was what this update was to provide.

In that letter, she also noted that the period of time that extraordinary measures may last is subject to considerable uncertainty due to a variety of factors, which are exacerbated this year by uncertainty related to the pandemic and calculations about inflows and outflows.

So, the October timeline that she — was referenced in there — or the October 1st date, I should say, was referenced — was because there's a very large reduction in the cash balance on October 1st — or we're projecting that — due to outflows on that day to meet our obligations to the Department of Defense.

So, she was giving a sense of what the timeline looks like, while not — while also conveying that we can't give a sense, at this point, on the length of time for extraordinary measures. We certainly expect Congress to act in a bipartisan manner, as they did three times under the prior administration, to raise the debt limit.

Q But given that uncertainty, is the White House communicating to congressional leaders that you'd like to see this debt limit extended before the recess for August?

MS. PSAKI: I'm not here to set a new deadline. I'm conveying to you the history and

conveying to you that we think it's clear Congress should act in a bipartisan manner to raise the debt limit as they have in the past.

Q And then just one more on the Bipartisan Infrastructure Framework. Is the White House getting involved in this dispute between Democrats and Republicans over transit funding? And are you recommending any solutions as to how that should be resolved? Are you backing Democrats who say it should remain with the 80/20 highway transit split?

MS. PSAKI: Oh, transit funding is obviously extremely important to the President — the "Amtrak President," as we may call him. And — but we believe that — that members can get this work done and can work through these issues quite quickly.

And as you know, the issue is about the balance of funding and how it would be allocated between different forms of infrastructure. But we're encouraged by their progress, they're having conversations, and we believe they can work through any disagreement.

I'm just going to go to the back because I'm — I'm not always good at that.

Mike Memoli, do you have a question today?

Q Yes, Jen. Thank you.

MS. PSAKI: Okay.

Q We've talked a lot with — (laughter) —

MS. PSAKI: You didn't raise your hand, but usually have a question.

Q I often do. We've talked about —

MS. PSAKI: I'll go to the back, back too. (Laughter.)

Q Now everyone is into it. We've talked a lot about this, this week — the protocols that are in place at the White House —

MS. PSAKI: Yep.

Q — to ensure the President's safety in — with COVID-19. But we've seen over the last few weeks the President has been traveling the country quite a bit. He's been engaging in more

uncontrolled environments. He went to an ice cream stop. He was on a rope line for almost an hour in Philly last week. He's doing a campaign event today. And we —

MS. PSAKI: Best hour he's spent probably in probably a while.

Q Given — I remember well how COVID changed the way he would campaign —

MS. PSAKI: Yeah.

Q — last year, what — to what extent is the rise in cases that we're seeing in this country leading any discussions behind the scenes about whether the President would continue to engage in this kind of activity in public settings where you can't control for people's vaccinations?

MS. PSAKI: Sure. Well, first, we're always going to abide by public health guidelines. And right now, the public health guidelines continue to be that if you're vaccinated — and we expect them to continue to be — if you're vaccinated, you're very much protected from severe illness from the virus.

And the President will continue to be a model in following those guidelines and also engaging with the public in a manner that, one, is his role as President of the United States and is certainly aligned with and appropriate according to those guidelines.

As you all know, he has an event later this evening with Governor — future governor, maybe — former Governor Terry McAuliffe in Virginia, where he will be certainly engaging with people and — with people of Virginia who are making decisions about their future leadership. But I expect he'll be engaging as he did at events last week.

So, nothing has changed about our approach or protocols over the past week or how you've seen him engage at the ice cream shop or at larger crowd events we've had.

Q And then a question about infrastructure. With some key votes coming up, obviously, next week, again, we've seen the President not necessarily engaging in the kind of meetings at the White House with lawmakers on this specific set of proposals in the way we have earlier on in the process. He's been meeting more with outside stakeholders. It seems like there's an outside-in pressure campaign. But can you give us an update on what his specific conversations might be with lawmakers involved in this process? We haven't really heard much about that.

MS. PSAKI: He has had a range of conversations with lawmakers over the phone. And he's always conveyed to his team that if it would be helpful to bring members down here, as he has continued to do, he's always happy to do that. The door to the Oval Office is always open. And he is available and will be through the course of the weekend, but also through the coming pivotal weeks as we work to get the infrastructure package across the finish line in the Senate and also the reconciliation bill moving forward.

Okay, we're going to go all the way to the very back. Todd Gillman, I see you somewhere there.

Q Thank you, Jen. So, the Texas Democrats who broke quorum from the legislature have — they're about halfway through their one-month quorum break. They've been trying really hard to get into a meeting, even if it's a Zoom meeting, with the President. Is he going to meet with them? Is he specifically not meeting with them because of fears that they are spreading COVID?

MS. PSAKI: No, he — the Vice President, who is leading our voting rights effort and our voting rights movement we're building across the country, met with these lawmakers last week, as you all know. And the President is very proud of their activism, their vocal support and advocacy for voting rights, but I don't have any meetings scheduled for him.

Q And in a kind of similar vein regarding COVID: Will the First Lady be quarantined away from the President when she gets back from Japan?

MS. PSAKI: The First Lady will ca- — follow all public health guidelines. I don't believe that's part of the protocols.

All right, let's go — let's see — to the middle here. I'm just jumping around today because, you know, trying better.

Go ahead.

Q Thanks, Jen. Does the White House have a reaction to Mississippi's decision ask the Supreme Court to overturn Roe v. Wade?

MS. PSAKI: Well, certainly, we are prominent sup- — or we are supporters — the President is a supporter of preserving Roe v. Wade. That is our position. In terms of a legisla- — or a legal reaction, I would point you to the Department of Justice.

Let's go to you, Patsy. Go ahead.

Q Thank you, Jen. I have a question on China. China just announced sanctions —

MS. PSAKI: Yeah.

Q — against six individuals and an entity in the U.S. in retaliation of sanctions imposed by the Biden administration on Chinese officials over Hong Kong. Do you think that this announcement will complicate or impact any plans for Deputy Secretary of State Wendy Sherman's visit to Tianjin? And is the administration concerned on the escalating sanctions — a potential escalating sanctions war?

MS. PSAKI: Well, first, I'm not aware of any changes to her planned trip. And certainly, we discussed not only areas where we agree, but areas where we disagree when we have engagements and diplomatic meetings.

In terms of the sanctions, we are aware, of course, of the reports that the PRC has imposed sanctions on several individuals and NGOs, including at least one official from the previous administration. We're undeterred by these actions and we remain fully committed to implementing all relevant U.S. sanctions authorities.

These actions are the latest examples of how Beijing punishes private citizens, companies, and civil society organizations as a way to send political signals and further illustrate the PRC's deteriorating — deteriorating investment climate and rising political risk.

These actions would follow the baseless sanctioning in March of two commissioners from the U.S. Commission on International Religious Freedom. The PRC's January sanctions on 21 — 28 U.S. officials and their July 2020 sanctions on U.S. officials and organizations promoting democracy and human rights around the world.

Americans of both parties oppose these outrageous moves to target those who defend universal human rights and fundamental freedoms. And Beijing's attempt to intimidate and bully internationally respected NGOs only demonstrate its further isolation from the world.

Q I do have another question on vaccine sharing.

MS. PSAKI: Let's keep going — I'm just going to keep going around because — go ahead. Go ahead, in the back. I'm just going to keep going around so I get to more people.

Q Thanks, Jen. On vaccines.

MS. PSAKI: Yeah.

Q You've been asked about the travel restrictions for international travel before —

MS. PSAKI: Yeah.

Q — but I'm going to try something different.

MS. PSAKI: Okay.

Q Would the President drop those restrictions if airlines adopted vaccine passports or vaccine mandates? I know you've, you know, sort of encouraged businesses to take steps to get everyone vaccinated that they possibly can.

MS. PSAKI: I would say, first, that there are ongoing working groups that are having discussions about how to, hopefully, move forward to a point where there is international travel and is returning something we would all like to see — not just for tourism, but for families to be reunited.

There are a range of topics in those discussions that are ongoing. The President receives regular briefings on them, but we rely on public health and medical advice on when we're going to determine changes to be made.

Q Has the President continued engaging with Chancellor Merkel on the subject? I know they talked about that at the bilateral press conference the other week.

MS. PSAKI: That was raised. He has not had another follow-up conversation with her since that point in time.

Why don't I go to the young man next to you.

Q Thanks, Jen. You know, a lot of parents are concerned about the upcoming school year. What's the White House doing to sort of make sure that we're not — we're not doing remote learning again nationwide?

MS. PSAKI: Well, our plan and our objective and our desire and commitment is to push for and ensure 100 percent of schools are open across the country. That's also, of course, up to school districts to implement.

But from the federal government, the role we have played is by work — advocating for funding in the American Rescue Plan that can help provide funding for mitigation measures for schools so that they can invest in social distancing opportunities or repairing vents that need to improve ventilation.

We're also — we've also put out public health guidance from the CDC that includes specific mitigation measures that schools can take.

And our Secretary of Education has been focused on this issue from the first day he was sworn into office — working across school districts to share best practices and ensure we can work towards returning kids to in-school learning.

Q The Delta doesn't change that, right?

MS. PSAKI: Delta has not changed our public health guidelines, no.

Okay, let's go back to the front, go ahead.

Q Just a quick follow-up on infrastructure. On the transit spending — we know that's important to the President —

MS. PSAKI: Yeah.

Q — is that a red line for him? If that is dropped from this package, would he still support it?

MS. PSAKI: I'm not setting red lines here, but we are confident that they can work through the funding issues and that — the breakdown of funding issues between Democrats and Republicans over the coming days.

Q And then one other question just on Alabama, and then I have one on Hunter Biden.

On Alabama, the big concern here — and the reason why these comments from the governor are so alarming is because of the low vaccination rates. Right? So, is there some concern from the White House? And does the administration fear that some elected leaders may just get so frustrated and accept this fact that there are just some people in this country that just may not want to get vaccinated?

MS. PSAKI: Well, I don't — I didn't hear those comments as accepting the fact. I heard those

comments as being frustrated that — you know, it's an effort to protect the citizens in your state and trying to figure out what steps you can take to encourage people to get vaccinated and save their lives and the lives of their loved ones.

We always knew it would be harder as more people got vaccinated. That's the stage we're in now. But we also believe that there is still opportunity through a range of approaches and tactics and partnerships with governors and leaders and civic leaders to get more people vaccinated. There a range of factors — you all — many of you have reported on — that are leading individuals in these five states with lower vaccination rates to get vaccinated.

Some are — is the Delta variant; and reporting, frankly; and fears of the transmissibility of the Delta variant. Some is, unfortunately, individuals are experiencing people in their communities, family members who are getting sick and getting hospitalized because of the transmissibility of the Delta variant.

I don't think we have com- — complex data quite yet to determine what is leading to the increase in vaccination rates in some of these states, but we think that's an encouraging sign. We know it's frustrating. We get it. But we have to stay at it to save people's lives.

Q And last, on Hunter Biden: You confirmed yesterday that he will be meeting with prospective buyers, but you also said that he's not going to have any conversation related —

MS. PSAKI: Not that he's meeting with prospective buyers — that he is attending gallery events that had been prior me- — prior planned and announced.

Q There could be prospective buyers there.

MS. PSAKI: He's not — those discussions will be happening with the gallerist. But that is different than meeting with prospective buyers.

Q If there are prospective buyers there, you said, yesterday, that he is not going to have any conversations related to the selling of art. How can the administration guarantee that?

MS. PSAKI: The selling of his art will all happen through galler- — the gallerist, and the names and individuals will be kept confidential. We will not be aware of, neither will he be aware of.

Q Is there anything stopping anyone from directly telling, though, Hunter Biden that they're going to purchase his art? And if they do, the American people won't know who they are.

MS. PSAKI: He will not know, we will not know who purchases his art.

Go ahead, Jeff.

Q The President said yesterday that the 25-person COVID group is quote, "investigating every aspect of any change." What specifically are they doing or is he looking for them to do in regards to the Delta variant? What information is he looking for them to bring back to him?

MS. PSAKI: You mean the CDC — or discussions with our public health experts?

I think what he was conveying, Jeff, is that he gets regular weekly, if not more frequent, updates from his COVID team about what is happening with the virus, the rise of certain variants, including the Delta variant, and certainly steps that they suggest we take as a result. That's an ongoing process. That's not new.

So, I think he's, of course, looking for their updates and guidance on what the spread is, where we're seeing the spread, what impacts we're having, and any mitigation measures they recommend we take from a public health and data-driven perspective.

Q On testing specifically, does the President believe that more testing should be done? It's fallen some 75 percent or so since November. What specifically do you think should be done or does he think should be done on testing?

MS. PSAKI: He relies on the guidance of his health and medical experts. If they are advising that that is a factor, then certainly his role would be to advocate for expanding it if — in his role as President, but that they obviously provide recommendations publicly as well.

Q And final thing here: You said it's not your role to place blame, but a President has a remarkable ability to use the bully pulpit, pick up the telephone. It happens all the time with — with corporations and things. What is he doing specifically with celebrities, perhaps, or with business leaders — like we saw the NFL this week — to use his power of the office to try and get some companies or groups to do mandates or make changes? Is he doing anything himself — reaching out like this?

MS. PSAKI: You mean, aside from getting —

Q Aside from public speeches.

MS. PSAKI: — aside from getting enough vaccine to —

Q Right.

MS. PSAKI: — make sure every American is vaccinated; and donating more to the world than any other country; and ensuring we're expanding accessibility to pharmacies, to community groups; and giving $3 billion to empower local voices to get into local communities to get people vaccinated? I'd say that's a fair amount that he's done.

Q But you said, several times, that it's not the role of the government to, essentially, you know, talk to private corporations. But a President talks to corporations and leaders all the time, certainly during the Rescue Plan, when he was Vice President. It happened all the time — talking to private corporations.

If a corner is to be turned here on the hesitancy, is there anything that he believes that he personally can do among some different leaders — not giving a public speech, but that he can do?

MS. PSAKI: Well, first, I think, I referenced the $3 billion because the most powerful and impactful role we've seen across the country, from community to community, is engaging, educating, and empowering those trusted local voices.

We know the President, the Vice President, Olivia Rodrigo, who we're very grateful to, and others have been out there advocating for the efficacy of the vaccine, and we're hopeful that's effective. And it can be. And he'll continue to do that, and we'll continue to look to partner with more voices and more creative, you know, well-known individuals to elevate the issue of vaccine — of the effectiveness of the vaccine.

But we've seen that's — that, actually, local voices — people you may not know, who may not have a Twitter following — are actually the most powerful people in this fight, and we'll continue to empower and fund those efforts.

Go ahead. Oh, Jeff, go ahead. And then, I'll go to Karen.

Q Thank you, Jen. Pfizer says the U.S. government is purchasing another 200 million doses of its vaccine —

MS. PSAKI: Mm-hmm.

Q — for children and for potential booster shots. Can you confirm the purchase? And can

you say whether the thinking about the need for booster shots is crystallized within the administration?

MS. PSAKI: First, HHS has all the specifics, but, yes, we have made that purchase. Here's the bottom line: We've always prepared for every scenario. The federal government is exercising an option in its contract with Pfizer to purchase these 200 million doses of the Pfizer vaccine to be delivered between the fall of 2021 and the spring of 2022 to prepare for future vaccination needs, including — as you referenced, Jeff — vaccines for children under 12 and possible booster shots, if studies show they are necessary.

I will note, I have said from the podium many times that we were like Boy Scouts and Girl Scouts, and we were going to prepare for every contingency. That's the job of the federal government — right? — to ensure we have maximum flexibility.

We don't know if we'll need a booster shot. That's going to be up to the research that's ongoing with the FDA. That's not a recommendation that's currently made.

We also don't know — we also can't predict what the outcome will be of research on kids under 12. We're certainly hopeful. And we don't know which vaccine will be most effective, but we want to have maximum flexibility, so this is an effort to provide us with that.

Q All right. And just one on infrastructure. We understand that Senate negotiators are looking at repurposing COVID relief funds for hospitals and nursing homes to pay for the — parts of the bill. Is that something the White House would support?

MS. PSAKI: Well, there's a range of final nitty-gritty discussions between both sides, but I'm not going to give feedback on each of the discussions from here.

Okay, Asma, go ahead.

Q Karen's turn.

Q Karen, go.

MS. PSAKI: Oh, Karen, sorry. Go ahead, Karen.

Q Thank you.

MS. PSAKI: Apologies.

Q Sort of keying off of what Jeff Zeleny was asking —

MS. PSAKI: Yeah.

Q — the NFL is telling teams that they could potentially forfeit games for a COVID outbreak among unvaccinated players, and the players could lose their pay for any missed games. Does the administration support a policy where players — or more broadly, employees — could lose pay if they are unvaccinated and cause a COVID outbreak at their place of work?

MS. PSAKI: Well, first, I'm not going to make a sweeping private-sector conclusion here. What I will say is the NFL policy is making clear how they're going to proceed with their season. That's their role to do. Right?

We certainly believe the biggest takeaway is that getting vaccinated is our ticket back to normal, and that vaccines are effective and allow all of us a high degree of protection, importantly, avoid hospitalization or death. So, this provides — this is guidance they determined — the NFL — about how they're going to proceed with their season. That is their role to do.

Q And there's a new model out from an organization that consults with the CDC, and it's predicting that the current surge in cases right now could continue until a peak in mid-October. The daily deaths potentially more than tripling where they are right now. What can the President do right now to prepare Americans for that possibility? He talked so much about the long winter last year. What about a potentially long fall?

MS. PSAKI: Well, I think the President's role right now is to continue to encourage people to get vaccinated because it is incredibly effective in prodect [sic] — protecting them from serious illness, from death, from hospitalization from the virus. That's the most powerful role he can play at this point in time.

George, go ahead.

Q Hi, Jen. This morning, the Cleveland Indians announced they're changing their name to "Guardians," and that's already become an issue in the Ohio Senate race. And the former President, just minutes ago, attacked it. Any reaction by the President or the White House?

MS. PSAKI: We certainly support their change of name. We may be on the other side of the President — former President — on that front, I would guess. I haven't seen his tweet, or

however he's communicating these days.

Go ahead.

Q Thanks, Jen. Two questions on the vaccine. First, you had mentioned yesterday that every individual at this White House has been, quote, "offered" a vaccine. So, can you clarify, is the administration not mandating vaccines for White House staff?

MS. PSAKI: No, we have not mandated.

Q Okay. And do you have a count or can you offer any confirmation to us on the percentage of employees who are vaccinated?

MS. PSAKI: I'm not going to provide that. I will see if there is more information to provide.

Q Can you offer any guidance then on how you're confirming vaccination status of employees?

MS. PSAKI: Well, they're vaccinated here in the White House Medical Unit, for the most part.

Go ahead. Oh, Kelly, I'm sorry. I'll come to you next.

Q Two questions: One, this administration has long claimed that you're trying to be the most transparent in history. If that's the case, why won't you just release the number of breakthrough cases that you've had of vaccinated staffers?

MS. PSAKI: Well, I think, first, we're in a very different place than we were six to seven months ago as it relates to the virus. And as many medical experts have said — inside and outside of the government — those who are vaccinated are protected from serious illness, most are asymptomatic — if they are individuals who are vaccinated who get the virus. And, you know, we are in a different place in terms of the impact of individuals who may have, as you said, breakthrough cases.

Q But why not just provide the number? Are you trying to hide something?

MS. PSAKI: No, but what is the — why do you need to have that information?

Q It's a case of transparency, in the interest of the public, knowing — having a better understanding of how breakthrough cases work here in the White House.

MS. PSAKI: Well, first, there are — the CDC tracks — and let me give you this information, too: The CDC tracks, across the country, of course, hospitalizations and deaths, as we have seen. They also do a great deal of tracking in cohorts and ensure that — so, let me give you a little more information on this, which I think — I don't know if it — hopefully, it's of interest.

So, the way that — because people have asked this before — so, the way the CDC is actively tracking breakthrough cases — there are tens of thousands of people across the country, in course, who are in what we are — what they call "cohort studies," which the CDC is actively monitoring.

For example, the CDC has a long-term care facility study where it is getting data from more than 14,000 long-term care facilities. CDC has a healthcare worker study where they monitor vaccinated healthcare workers who got tested — who get tested with PCR tests every single week. And CDC also collects what they call "passive surveillance," which is where hospitals provide CDC with data when they identify someone who is hospitalized but has been vaccinated.

So there's a range of means our public health officials are tracking, across the country, across D.C., across any individuals here about who is vaccinated, who is getting the virus, getting hospitalized — hopefully not; it remains a small percentage.

Q And following up on the questions about Hunter Biden and his art shows. Are there any specific procedures you can tell us that are being put in place to ensure that these conversations remain, as you say, not about the sales. Will he get ethics training? Will he have to report afterwards about the conversations? Anything specific you can tell us about how you are monitoring this?

MS. PSAKI: Well, again, I think it is certainly a commitment that has been made by all parties involved. He is not involved in the sale or discussions about the sale of his art. And he will not be informed of the sale — of the sale of his art and who is purchasing that art. That is a commitment that's been made, and we expect that all parties would abide by it.

Go ahead, Kelly.

Q I wanted to ask about the CDC tracking —

MS. PSAKI: Sure.

Q — because — and you gave us some information just now, but —

MS. PSAKI: Yeah.

Q — as of May 1st, they stopped tracking breakthrough cases that did not result in hospitalization or death, with the exception of those kinds of tests that you just described. Should there be a more broader net on breakthrough cases? Would the President support that to get a better picture of breakthrough?

And those White House employees, staff — EOP, on the campus in any capacity — who are not vaccinated, are they working here or are they working from home?

MS. PSAKI: Well, any individual who has chosen not to be vaccinated, same as in the press corps, the public health guidance is to wear a mask. That is the public health guidance that's provided to employees as well.

In terms of the — it is much more expensive than hospitalizations that — that was what I was trying to convey. What the CDC does is they have these — they tra- — actively track breakthrough cases through these cohorts of individuals who are vulnerable populations, who are hi- — have high risks of exposure. And they, of course, incl- — as I noted — long-term care facilities, healthcare workers, and others who would be in those cohorts and categories.

I would also note that because the vast majority of individuals who are vaccinated who get — test positive for COVID may be asymptomatic or have moderate or minimal cases, those are cases we may not know — we may not know about, right?

Q But they're — the CDC says, as of May 1st, they stopped tracking breakthrough cases that don't result in hospitalizations.

MS. PSAKI: They do track through these cohorts, which is a large swath of people who would be vulnerable or on the frontlines of exposure.

Q My periodic question: It's now past —

MS. PSAKI: Sure.

Q — six months. When can we expect to know about a physical exam for the President? And what are the plans for that?

MS. PSAKI: There is — absolutely he will have a physical exam. Absolutely you will know about the physical exam. I don't have a date for you at this point in time. And I expect you will continue to ask, as you should.

Go ahead.

Q Yeah, Jen, thank you. This is sort of a rhetorical question —

MS. PSAKI: Oh.

Q — following up on vaccinations.

MS. PSAKI: Okay.

Q It is a shame that people have to get very sick and some people have to die in order to increase the vaccination rate in many parts of this country.

MS. PSAKI: Mm-hmm.

Q But isn't that, I guess, a logical order of how this would play out? Or is there a political component to it, do you think?

MS. PSAKI: I'm not sure I'm following your question. Try again. Or tell me more about what you're looking for.

Q Well, wouldn't it be standard practice that people, if more people are getting sick in a certain area, that the people in that area who are unvaccinated would say, "Gee, I really need to go get vaccinated." Isn't that a logical order for this? Or is there a political component, do you think, that has kept people away from being vaccinated?

MS. PSAKI: Look, I think there are a range of reasons we've seen across the country why individuals have not yet been vaccinated. Some of it is misinformation — a large amount, in our view. Some of it is fear. Some of it is, they may feel, time. Some of it is they're young, and they feel they're Superman or Superwoman, and they're not going to get sick.

That shouldn't be; we don't want that to be the order of events. It shouldn't be that someone should have to know a neighbor who gets sick and hospitalized to motivate them to go to a hospital — I mean to go to get vaccinated. We don't want that to be the case.

We have seen anecdotally and through some of your — all of your reporting that that has been the case in some communities. But certainly, our objective is to communicate to people this is not a political issue, it is not a partisan issue; this is about protecting lives. The virus does not discriminate between political party affiliation.

Go ahead.

Q The White House noted yesterday that 40 percent of cases are coming from three states with low vaccination rates: Florida, Texas, and Missouri.

All three of those states have governors who, in recent weeks, have criticized the White House's strategy. One of them is even fundraising off of it, as you are probably aware.

What's being done to engage those governors, come up with a common message, common strategy to try and be one team with those governors in terms of fighting this virus?

MS. PSAKI: Well, I would say, first, our public health experts work with governors from across the country and work with local health officials from across the country in all of these states, especially the ones at this point in time where there are lower vaccination rates and we're seeing the Delta variant spread.

And this is one of the reasons we rely so much on — hold on, I'm going to sneeze. Okay, hold on. Okay, maybe it will come back. (Laughter.) This is wh- — sorry, (inaudible) —

This is why we rely on local messengers and why we rely on trusted voices. Because whether it's the President of the United States or the governor, sometimes those aren't the people you trust. Sometimes that is too political or partisan for people. We understand that.

That's why we rely on and we're funding and empowering local, trusted voices who aren't seen through a political prism.

Q And then on the West Coast right now, we're seeing wildfires in Oregon and Northern California.

MS. PSAKI: Yeah.

Q What steps is the administration taking to combat the current fires and also prevent additional fires this summer?

MS. PSAKI: Well, I appreciate you asking about this because I know this has gotten a lot of attention across the country, and we just haven't talked about it a lot. There's so much going on.

One, the President receives regular reports on the wildfire situation; he's quite focused on it. As I think you're probably aware but others may not be, the National Wild- — Wildland Fire Preparedness Level is at a five, which is the highest level due to significant fire activity.

And as of today, 2.5 million acres have burned across the United States. In the past two weeks alone the number of large, uncontained fires across the United States has increased by nearly 90 percent.

So, right now, what we're doing: One, the President is very focused on this and wants regular updates. He's regularly met with Western governors, and I expect we'll do that again soon.

The FEMA Administrator is visiting Idaho, Oregon, and California this week to meet with state, federal, and Tribal partners and emergency groups about worsen — the worsening wildfire situation, to coordinate response efforts and discuss how the regions are addressing climate change and ongoing resilience work.

We are also closely coordinating with officials on the frontlines to provide federal assistance as needed, including by recently approving Fire Management Assistance Grants for fire departments in Oregon, California, and Washington, which are where there's the collective threat to homes and major communities.

And we're also continuing to monitor the — monitor these fires from here. Again, the President receives regular updates and he's quite focused on this.

Go ahead.

Q On Cuba —

MS. PSAKI: Yeah.

Q — Congresswoman Salazar says that the administration could turn the Internet back on for Cubans within minutes. I guess there's this technology to allow high-tech balloons to float over Cuba to act as towers. What's being done? Or can you provide an update on restoring Internet services to Cuba?

MS. PSAKI: I wish it was that easy. We are exploring a range of options. We are quite focused and interested in restoring Internet access to the people of Cuba, which we actually — which we absolutely believe, and agree, I would say, would provide information, would allow individuals to communicate. And we feel if we can get it done, that would be a great step forward and beneficial to the people of Cuba.

Go ahead.

Q Thank you, ma'am. You mentioned at the top that Republicans had also increased the debt ceiling and certainly, you know, spending has been bipartisan for many years. I'm wondering what the President's long-term view of the country's balance sheets are, given that under current long-term CBO estimates, debt is never again expected to dip below 100 percent of gross domestic product, and then, within 30 years, it is projected to hit 202 percent of gross domestic product.

MS. PSAKI: Well, first, I would say the President has proposed a way to pay for his proposals, which is something that is a fiscally responsible step some of his predecessors — the most recent one — did not do when he worked and advocated to support the passing of $2 trillion in tax cuts that did not bear out the financial benefit he promised and also certainly added to the deficit.

The President takes these issues seriously. He is focused on being a President who cares about the future of our — the next generations. And I think his actions have borne that out.

Q And then a quick follow-up: There was a lot of discussion about masking the other day. This administration has always followed CDC guidance.

MS. PSAKI: Yeah.

Q If the CDC was to say, "We need to return to masking," would this administration follow suit?

MS. PSAKI: We're always going to follow the guidance of our health and medical experts.

Go ahead.

Q Thanks, Jen. On the vaccine immunity: Given that Pfizer's now seeing waning immunity and separate from who is vaccinated and who is not, is the White House looking at models and projections that say, in the next year, as everyone who has been vaccinated could start to lose

that immunity, what does that look like for hospitalizations and deaths, et cetera?

MS. PSAKI: Well, first, I would certainly point to our health and medical experts to answer questions about future projections about the impact of waning immunity. I will say that as they look at this data and assess from our — from the CDC and other public health entities in the government, they certainly talked to private-sector companies like Pfizer, but that's only one source of data and engagement. They look at a range of data across the board as they make projections. So we really rely on their broad data and projections as we assess what the future looks like.

Q Just a follow-up on Afghanistan as well: You mentioned continuing U.S. support. Does that include continuing military support? I mean, we've seen a number of airstrikes that the U.S. has launched on Taliban targets over the last 30 days. Could that continue past the end of the military mission at the end of August?

MS. PSAKI: I don't have anything on that for you. I'd certainly point to the Department of Defense. But what I'm — what I was communicating about was, you know, over the coming weeks, we maintain our authorities, as you know, and we provide — we've provided a range of training and security assistance equipment to the Afghans and the leaders of Afghanistan as we transition to bringing our men and women home.

Q Thanks, Jen.

MS. PSAKI: Thanks so much, everyone. Have a great weekend.

2:04 P.M. EDT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

Remarks by President Biden on Fighting the COVID-19 Pandemic, The White House (Sept. 9, 2021)

EXHIBIT A-7

BRIEFING ROOM

Remarks by President Biden on Fighting the COVID-19 Pandemic

SEPTEMBER 09, 2021 • SPEECHES AND REMARKS

5:02 P.M. EDT

THE PRESIDENT: Good evening, my fellow Americans. I want to talk to you about where we are in the battle against COVID-19, the progress we've made, and the work we have left to do.

And it starts with understanding this: Even as the Delta variant 19 [sic] has — COVID-19 — has been hitting this country hard, we have the tools to combat the virus, if we can come together as a country and use those tools.

If we raise our vaccination rate, protect ourselves and others with masking and expanded testing, and identify people who are infected, we can and we will turn the tide on COVID-19.

It will take a lot of hard work, and it's going to take some time. Many of us are frustrated with the nearly 80 million Americans who are still not vaccinated, even though the vaccine is safe, effective, and free.

You might be confused about what is true and what is false about COVID-19. So before I outline the new steps to fight COVID-19 that I'm going to be announcing tonight, let me give you some clear information about where we stand.

First, we have cons- — we have made considerable progress
in battling COVID-19. When I became President, about 2 million Americans were fully vaccinated. Today, over 175 million Americans have that protection.

Before I took office, we hadn't ordered enough vaccine for every American. Just weeks in office, we did. The week before I took office, on January 20th of this year, over 25,000 Americans died that week from COVID-19. Last week, that grim weekly toll was down 70 percent.

And in the three months before I took office, our economy was faltering, creating just 50,000 jobs a month. We're now averaging 700,000 new jobs a month in the past three months.

This progress is real. But while America is in much better shape than it was seven months ago when I took office, I need to tell you a second fact.

We're in a tough stretch, and it could last for a while. The highly contagious Delta variant that I began to warn America about back in July spread in late summer like it did in other countries before us.

While the vaccines provide strong protections for the vaccinated, we read about, we hear about, and we see the stories of hospitalized people, people on their death beds, among the unvaccinated over these past few weeks.

This is a pandemic of the unvaccinated. And it's caused by the fact that despite America having an unprecedented and successful vaccination program, despite the fact that for almost five months free vaccines have been available in 80,000 different locations, we still have nearly 80 million Americans
who have failed to get the shot.

And to make matters worse, there are elected officials actively working to undermine the fight against COVID-19. Instead of encouraging people to get vaccinated and mask up, they're ordering mobile morgues for the unvaccinated dying from COVID in their communities. This is totally unacceptable.

Third, if you wonder how all this adds up, here's the math: The vast majority of Americans are doing the right thing. Nearly three quarters of the eligible have gotten at least one shot, but one quarter has not gotten any. That's nearly 80 million Americans not vaccinated. And in a country as large as ours, that's 25 percent minority. That 25 percent can cause a lot of damage — and they are.

The unvaccinated overcrowd our hospitals, are overrunning the emergency rooms and intensive care units, leaving no room for someone with a heart attack, or ~~pancreitis~~ [pancreatitis], or cancer.

And fourth, I want to emphasize that the vaccines provide very strong protection from severe illness from COVID-19. I know there's a lot of confusion and misinformation. But the world's leading scientists confirm that if you are fully vaccinated, your risk of severe illness from COVID-19 is very low.

In fact, based on available data from the summer, only one of out of every 160,000 fully vaccinated Americans was hospitalized for COVID per day.

These are the facts.

So here's where we stand: The path ahead, even with the Delta variant, is not nearly as bad as last winter. But what makes it incredibly more frustrating is that we have the tools to combat COVID-19, and a distinct minority of Americans –supported by a distinct minority of elected officials — are keeping us from turning the corner. These pandemic politics, as I refer to, are making people sick, causing unvaccinated people to die.

We cannot allow these actions to stand in the way of protecting the large majority of Americans who have done their part and want to get back to life as normal.

As your President, I'm announcing tonight a new plan to require more Americans to be vaccinated, to combat those blocking public health.

My plan also increases testing, protects our economy, and will make our kids safer in schools. It consists of six broad areas of action and many specific measures in each that — and each of those actions that you can read more about at WhiteHouse.gov. WhiteHouse.gov.

The measures — these are going to take time to have full impact. But if we implement them, I believe and the scientists indicate, that in the months ahead we can reduce the number of unvaccinated Americans, decrease hospitalizations and deaths, and allow our children to go to school safely and keep our economy strong by keeping businesses open.

First, we must increase vaccinations among the unvaccinated with new vaccination requirements. Of the nearly 80 million eligible Americans who have not gotten vaccinated, many said they were waiting for approval from the Food and Drug Administration — the FDA. Well, last month, the FDA granted that approval.

So, the time for waiting is over. This summer, we made progress through the combination of vaccine requirements and incentives, as well as the FDA approval. Four million more people got their first shot in August than they did in July.

But we need to do more. This is not about freedom or personal choice. It's about protecting yourself and those around you — the people you work with, the people you care about, the people you love.

My job as President is to protect all Americans.

So, tonight, I'm announcing that the Department of Labor is developing an emergency rule to require all employers with 100 or more employees, that together employ over 80 million workers, to ensure their workforces are fully vaccinated or show a negative test at least once a week.

Some of the biggest companies are already requiring this: United Airlines, Disney, Tysons Food, and even Fox News.

The bottom line: We're going to protect vaccinated workers from unvaccinated co-workers. We're going to reduce the spread of COVID-19 by increasing the share of the workforce that is vaccinated in businesses all across America.

My plan will extend the vaccination requirements that I previously issued in the healthcare field. Already, I've announced, we'll be requiring vaccinations that all nursing home workers who treat patients on Medicare and Medicaid, because I have that federal authority.

Tonight, I'm using that same authority to expand that to cover those who work in hospitals, home healthcare facilities, or other medical facilities –- a total of 17 million healthcare workers.

If you're seeking care at a health facility, you should be able to know that the people treating you are vaccinated. Simple. Straightforward. Period.

Next, I will sign an executive order that will now require all executive branch federal employees to be vaccinated — all. And I've signed another executive order that will require federal contractors to do the same.

If you want to work with the federal government and do business with us, get vaccinated. If you want to do business with the federal government, vaccinate your workforce.

And tonight, I'm removing one of the last remaining obstacles that make it difficult for you to get vaccinated.

The Department of Labor will require employers with 100 or more workers to give those workers paid time off to get vaccinated. No one should lose pay in order to get vaccinated or take a loved one to get vaccinated.

Today, in total, the vaccine requirements in my plan will affect about 100 million Americans –- two thirds of all workers.

And for other sectors, I issue this appeal: To those of you running large entertainment venues — from sports arenas to concert venues to movie theaters — please require folks to get vaccinated or show a negative test as a condition of entry.

And to the nation's family physicians, pediatricians, GPs — general practitioners –- you're the most trusted medical voice to your patients. You may be the one person who can get someone to change their mind about being vaccinated.

Tonight, I'm asking each of you to reach out to your unvaccinated patients over the next two weeks and make a personal appeal to them to get the shot. America needs your personal involvement in this critical effort.

And my message to unvaccinated Americans is this: What more is there to wait for? What more do you need to see? We've made vaccinations free, safe, and convenient.

The vaccine has FDA approval. Over 200 million Americans have gotten at least one shot.

We've been patient, but our patience is wearing thin. And your refusal has cost all of us. So, please, do the right thing. But just don't take it from me; listen to the voices of unvaccinated Americans who are lying in hospital beds, taking their final breaths, saying, "If only I had gotten vaccinated." "If only."

It's a tragedy. Please don't let it become yours.

The second piece of my plan is continuing to protect the vaccinated.

For the vast majority of you who have gotten vaccinated, I understand your anger at those who haven't gotten vaccinated. I understand the anxiety about getting a "breakthrough" case.

But as the science makes clear, if you're fully vaccinated, you're highly protected from severe illness, even if you get COVID-19.

In fact, recent data indicates there is only one confirmed positive case per 5,000 fully vaccinated Americans per day.

You're as safe as possible, and we're doing everything we can to keep it that way — keep it that way, keep you safe.

That's where boosters come in — the shots that give you even more protection than after your second shot.

Now, I know there's been some confusion about boosters. So, let me be clear: Last month, our top government doctors announced an initial plan for booster shots for vaccinated Americans. They believe that a booster is likely to provide the highest level of protection yet.

Of course, the decision of which booster shots to give, when to start them, and who will give them, will be left completely to the scientists at the FDA and the Centers for Disease Control.

But while we wait, we've done our part. We've bought enough boosters — enough booster shots — and the distribution system is ready to administer them.

As soon as they are authorized, those eligible will be able to get a booster right away in tens of thousands of site across the — sites across the country for most Americans, at your nearby drug store, and for free.

The third piece of my plan is keeping — and maybe the most important — is keeping our children safe and our schools open. For any parent, it doesn't matter how low the risk of any illness or accident is when it comes to your child or grandchild. Trust me, I know.

So, let me speak to you directly. Let me speak to you directly to help ease some of your worries.

It comes down to two separate categories: children ages 12 and older who are eligible for a vaccine now, and children ages 11 and under who are not are yet eligible.

The safest thing for your child 12 and older is to get them vaccinated. They get vaccinated for a lot of things. That's it. Get them vaccinated.

As with adults, almost all the serious COVID-19 cases we're seeing among adolescents are in unvaccinated 12- to 17-year-olds — an age group that lags behind in vaccination rates.

So, parents, please get your teenager vaccinated.

What about children under the age of 12 who can't get vaccinated yet? Well, the best way for a parent to protect their child under the age of 12 starts at home. Every parent, every teen

sibling, every caregiver around them should be vaccinated.

Children have four times higher chance of getting hospitalized if they live in a state with low vaccination rates rather than the states with high vaccination rates.

Now, if you're a parent of a young child, you're wondering when will it be — when will it be — the vaccine available for them. I strongly support an independent scientific review for vaccine uses for children under 12. We can't take shortcuts with that scientific work.

But I've made it clear I will do everything within my power to support the FDA with any resource it needs to continue to do this as safely and as quickly as possible, and our nation's top doctors are committed to keeping the public at large updated on the process so parents can plan.

Now to the schools. We know that if schools follow the science and implement the safety measures — like testing, masking, adequate ventilation systems that we provided the money for, social distancing, and vaccinations — then children can be safe from COVID-19 in schools.

Today, about 90 percent of school staff and teachers are vaccinated. We should get that to 100 percent. My administration has already acquired teachers at the schools run by the Defense Department — because I have the authority as President in the federal system — the Defense Department and the Interior Department — to get vaccinated. That's authority I possess.

Tonight, I'm announcing that we'll require all of nearly 300,000 educators in the federal paid program, Head Start program, must be vaccinated as well to protect your youngest — our youngest — most precious Americans and give parents the comfort.

And tonight, I'm calling on all governors to require vaccination for all teachers and staff. Some already have done so, but we need more to step up.

Vaccination requirements in schools are nothing new. They work. They're overwhelmingly supported by educators and their unions. And to all school officials trying to do the right thing by our children: I'll always be on your side.

Let me be blunt. My plan also takes on elected officials and states that are undermining you and these lifesaving actions. Right now, local school officials are trying to keep children safe in a pandemic while their governor picks a fight with them and even threatens their salaries or their jobs. Talk about bullying in schools. If they'll not help — if these governors won't help us beat the pandemic, I'll use my power as President to get them out of the way.

The Department of Education has already begun to take legal action against states undermining protection that local school officials have ordered. Any teacher or school official whose pay is withheld for doing the right thing, we will have that pay restored by the federal government 100 percent. I promise you I will have your back.

The fourth piece of my plan is increasing testing and masking. From the start, America has failed to do enough COVID-19 testing. In order to better detect and control the Delta variant, I'm taking steps tonight to make testing more available, more affordable, and more convenient. I'll use the Defense Production Act to increase production of rapid tests, including those that you can use at home.

While that production is ramping up, my administration has worked with top retailers, like Walmart, Amazon, and Kroger's, and tonight we're announcing that, no later than next week, each of these outlets will start to sell at-home rapid test kits at cost for the next three months. This is an immediate price reduction for at-home test kits for up to 35 percent reduction.

We'll also expand — expand free testing at 10,000 pharmacies around the country. And we'll commit — we're committing $2 billion to purchase nearly 300 million rapid tests for distribution to community health centers, food banks, schools, so that every American, no matter their income, can access free and convenient tests. This is important to everyone, particularly for a parent or a child — with a child not old enough to be vaccinated. You'll be able to test them at home and test those around them.

In addition to testing, we know masking helps stop the spread of COVID-19. That's why when I came into office, I required masks for all federal buildings and on federal lands, on airlines, and other modes of transportation.

Today — tonight, I'm announcing that the Transportation Safety Administration — the TSA — will double the fines on travelers that refuse to mask. If you break the rules, be prepared to pay.

And, by the way, show some respect. The anger you see on television toward flight attendants and others doing their job is wrong; it's ugly.

The fifth piece of my plan is protecting our economic recovery. Because of our vaccination program and the American Rescue Plan, which we passed early in my administration, we've had record job creation for a new administration, economic growth unmatched in 40 years. We cannot let unvaccinated do this progress — undo it, turn it back.

So tonight, I'm announcing additional steps to strengthen our economic recovery. We'll be expanding COVID-19 Economic Injury Disaster Loan programs. That's a program that's going to allow small businesses to borrow up to $2 million from the current $500,000 to keep going if COVID-19 impacts on their sales.

These low-interest, long-term loans require no repayment for two years and be can used to hire and retain workers, purchase inventory, or even pay down higher cost debt racked up since the pandemic began. I'll also be taking additional steps to help small businesses stay afloat during the pandemic.

Sixth, we're going to continue to improve the care of those who do get COVID-19. In early July, I announced the deployment of surge response teams. These are teams comprised of experts from the Department of Health and Human Services, the CDC, the Defense Department, and the Federal Emergency Management Agency — FEMA — to areas in the country that need help to stem the spread of COVID-19.

Since then, the federal government has deployed nearly 1,000 staff, including doctors, nurses, paramedics, into 18 states. Today, I'm announcing that the Defense Department will double the number of military health teams that they'll deploy to help their fellow Americans in hospitals around the country.

Additionally, we're increasing the availability of new medicines recommended by real doctors, not conspir- — conspiracy theorists. The monoclonal antibody treatments have been shown to reduce the risk of hospitalization by up to 70 percent for unvaccinated people at risk of developing sefe- — severe disease.

We've already distributed 1.4 million courses of these treatments to save lives and reduce the strain on hospitals. Tonight, I'm announcing we will increase the average pace of shipment across the country of free monoclonal antibody treatments by another 50 percent.

Before I close, let me say this: Communities of color are disproportionately impacted by this virus. And as we continue to battle COVID-19, we will ensure that equity continues to be at the center of our response. We'll ensure that everyone is reached. My first responsibility as President is to protect the American people and make sure we have enough vaccine for every American, including enough boosters for every American who's approved to get one.

We also know this virus transcends borders. That's why, even as we execute this plan at home, we need to continue fighting the virus overseas, continue to be the arsenal of vaccines.

We're proud to have donated nearly 140 million vaccines over 90 countries, more than all other countries combined, including Europe, China, and Russia combined. That's American leadership on a global stage, and that's just the beginning.

We've also now started to ship another 500 million COVID vaccines — Pfizer vaccines — purchased to donate to 100 lower-income countries in need of vaccines. And I'll be announcing additional steps to help the rest of the world later this month.

As I recently released the key parts of my pandemic preparedness plan so that America isn't caught flat-footed when a new pandemic comes again — as it will — next month, I'm also going to release the plan in greater detail.

So let me close with this: We have so- — we've made so much progress during the past seven months of this pandemic. The recent increases in vaccinations in August already are having an impact in some states where case counts are dropping in recent days. Even so, we remain at a critical moment, a critical time. We have the tools. Now we just have to finish the job with truth, with science, with confidence, and together as one nation.

Look, we're the United States of America. There's nothing — not a single thing — we're unable to do if we do it together. So let's stay together.

God bless you all and all those who continue to serve on the frontlines of this pandemic. And may God protect our troops.

Get vaccinated.

5:28 P.M. EDT

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

The Centers for Disease Control and Prevention's COVID Data Tracker, COVID-19 Vaccinations in the United States

EXHIBIT A-8

Centers for Disease Control and Prevention

COVID Data Tracker

United States at a Glance Collapse

United States
At a Glance

Cases Total **46,910,412**
Last 30 Days

Deaths Total **759,552**
Last 30 Days

79.4% of People 12+ with At Least One Vaccination

Community Transmission High

The <12-years-old data displayed is the result of vaccination trial data and historical data that is subject to change. Updated vaccination data for 5-11 year-olds will be added to COVID Data Tracker in the coming days.

COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine Deliveries and Administration; Maps, charts, and data provided by CDC, updates daily by 8 pm ET†
Represents all vaccine partners including jurisdictional partner clinics, retail pharmacies, long-term care facilities, dialysis centers, Federal Emergency Management Agency and Health Resources and Services Administration partner sites, and federal entity facilities.

Who is eligible for a COVID-19 vaccine booster dose?
How Do I Find a COVID-19 Vaccine?
View Footnotes and Download Data

Total Vaccine Doses
Delivered 553,802,305
Administered 440,559,613

Learn more about the distribution of vaccines.

195.1M
People fully vaccinated

29.3M
People received a booster dose**

At Least One Dose | Fully Vaccinated | Booster Dose

Fully Vaccinated* People	Count	Percent of US Population
Total	195,120,47	58.8%
Population ≥ 12 Years of Age	194,982,994	68.8%
Population ≥ 18 Years of Age	182,162,58	70.5%
Population ≥ 65 Years of Age	47,126,631	86%

***For surveillance purposes, COVID Data Tracker counts people as being "fully vaccinated" if they received two doses on different days (regardless of time interval) of the two-dose mRNA series or received one dose of a single-dose vaccine.**

****The count of people who received a booster dose includes anyone who is fully vaccinated and has received another dose of COVID-19 vaccine since August 13, 2021. This includes people who received booster doses and people who received additional doses.**

About these data

CDC | Data as of: November 14, 2021 6:00am ET. Posted: Sunday, November 14, 2021 3:40 PM ET

View:
- (•) Total Doses
- ( ) People

Show:
- (•) Administered
- ( ) Delivered

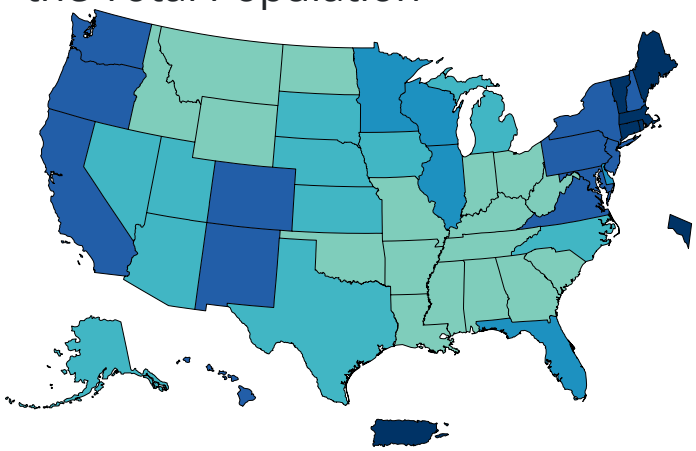
Metric:
- ( ) Count
- (•) Rate per 100,000

Population:
- (•) Total Population
- ( ) Population ≥ 12 Years of Age
- ( ) Population ≥ 18 Years of Age
- ( ) Population ≥ 65 Years of Age

This shows the number of doses administered within the state or territory for every 100,000 people of the total population. It does not reflect the residency of the

person receiving the vaccine, but where they received it.

Total Doses Administered Reported to the CDC by State/Territory and for Select Federal Entities per 100,000 of the Total Population



Territories

GU AS RP FM MP MH VI

Federal Entities

BoP DoD IHS VHA

Data for Federal Entities are presented here and are also incorporated into the respective jurisdictional totals

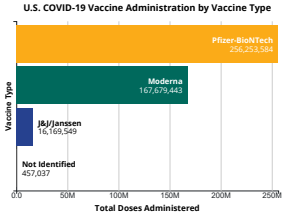
Total Doses Administered per 100,000

No Data 0 1 - 120,000

120,001 - 130,000 130,001 - 140,000

140,001 - 150,000 150,001 +

Download Map



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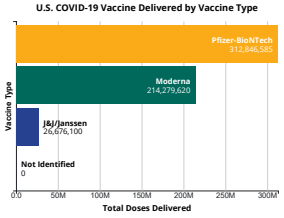

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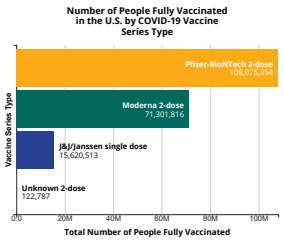

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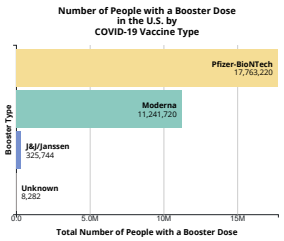

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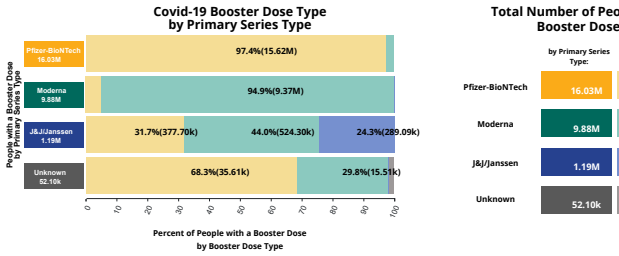


Download

COVID-19 Booster Dose Type by Primary Series Type: This graph is limited to people who are fully vaccinated and have received a booster dose. It illustrates the vaccine manufacturer (i.e., vaccine type) of the COVID-19 primary series received, as well as the manufacturer of the booster dose received. The graph demonstrates that while some vaccine recipients received the same vaccine type for their primary series and booster dose, others received one type for their primary series and a different type for their booster dose.

Data Downloads and Footnotes

Expand each accordion to view data table and download data

View Historic Vaccination Data

Data Table for COVID-19 Vaccinations in the United States +

Footnotes +

Dialysis Vaccination Data Dashboard

Dialysis facilities report weekly COVID-19 vaccination data for patients and healthcare personnel to CDC's National Healthcare Safety Network (NHSN).

Nursing Home Vaccination Data Dashboard

Long-term care facilities report weekly COVID-19 vaccination data for residents and healthcare personnel to CDC's National Healthcare Safety Network (NHSN).

Want to know more about trends in COVID-19 US vaccinations?

See the latest trends in the number of COVID-19 vaccinations given in the United States.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

CDCHAN-00447: Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021 (July 27, 2021)

EXHIBIT A-9

Centers for Disease Control and Prevention

Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021

HAN HEALTH ALERT NETWORK

This is an official CDC HEALTH ADVISORY

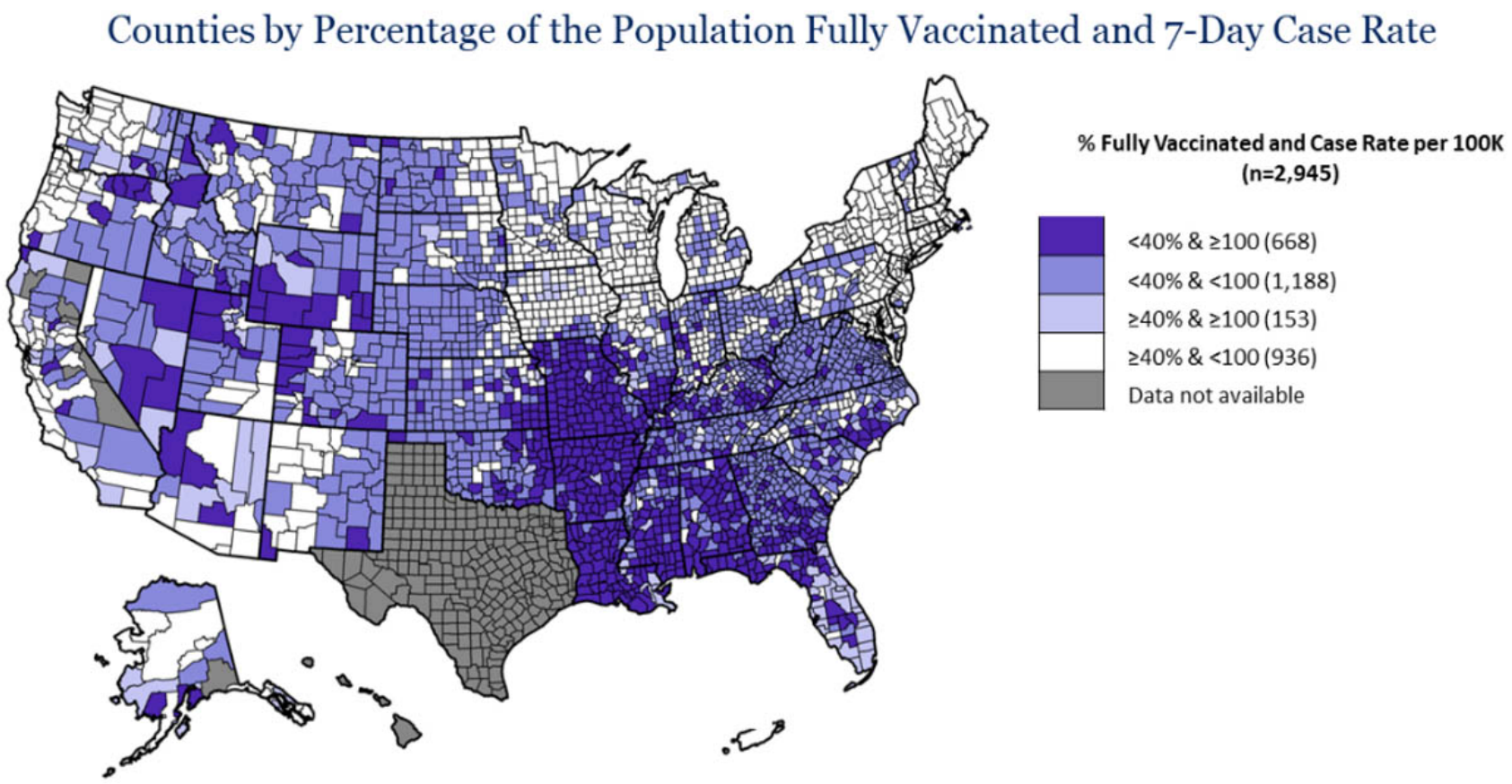
Distributed via the CDC Health Alert Network
July 27, 2021, 4:00 PM ET
CDCHAN-00447

Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network Health Advisory to notify public health practitioners and clinicians about the urgent need to increase COVID-19 vaccination coverage (i.e., the percentage of the population fully vaccinated) across the United States to prevent surges in new infections that could increase COVID-19 related morbidity and mortality, overwhelm healthcare capacity, and widen existing COVID-19-related health disparities. Increasing vaccination coverage is especially urgent in areas where current coverage is low. Unvaccinated persons account for the majority of new COVID-19 infections, hospitalizations, and deaths. Currently circulating SARS-CoV-2 variants of concern, especially the highly infectious Delta variant (B.1.617.2), are accelerating spread of infection. Unvaccinated and partially vaccinated people need to practice all recommended prevention measures until fully vaccinated. In areas with substantial and high transmission, CDC recommends that fully vaccinated individuals wear a mask in public indoor settings to help prevent the spread of Delta and protect others.

Background

COVID-19 case rates are rising again after a period of decline: COVID-19 cases have increased over 300% nationally from June 19 to July 23, 2021, along with parallel increases in hospitalizations and deaths driven by the highly transmissible B.1.617.2 (Delta) variant. While significant progress has been made to make COVID-19 vaccine widely available, disparities in vaccination coverage persist across population groups and geographic areas. As of July 23, 2021, 1,856 (63.0%) of the 2,945 counties with available vaccination data have particularly low vaccination coverage, defined here as <40% of the population being fully vaccinated. As of July 23, 2021, among the counties with vaccine coverage <40%, 36.0% (N = 668) have COVID-19 incidence rates in the high burden level (≥100 cases/100,000 over the last seven days) (see figure below, and further data at COVID Tracker).



Overall, the majority (81.4%) of counties with high COVID-19 incidence rates are found in communities with low vaccination coverage. As COVID-19 case counts continue to rise nationally, areas with lower vaccination coverage are at especially high risk for a surge in cases.

Most cases of COVID-19 and hospitalizations are in unvaccinated individuals: While COVID-19 vaccines authorized in the United States remain effective against SARS-CoV-2 infection and severe disease, some infections among vaccinated persons (i.e., breakthrough infections) are anticipated and have been reported. However, the majority of COVID-19 cases and hospitalizations are occurring among individuals who are not fully vaccinated. From January through May 2021, of the more than 32,000 laboratory-confirmed COVID-19-associated hospitalizations in adults ≥18 years of age for whom vaccination status is known, <3% of hospitalizations occurred in fully vaccinated persons.

The COVID-19 Delta variant is widely prevalent and more infectious than prior strains: The COVID-19 Delta variant currently accounts for more than 80% of all COVID-19 cases in the United States. This variant is significantly more infectious than prior SARS-CoV-2 variants and has led to a rapid rise in COVID-19 cases in other countries, including the United Kingdom and Israel. Emerging evidence suggests that fully vaccinated people who do become infected with the Delta variant are at risk for transmitting it to others.

COVID-19 vaccination is our most effective strategy to prevent infection and severe disease: Vaccination is a priority national strategy to interrupt SARS-CoV-2 transmission, protect personal and public health, and preserve healthcare system capacity. COVID-19 vaccines are safe and recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Immunologic data support the role of Food and Drug Administration (FDA)-authorized COVID-19 vaccines in offering protection against the known currently circulating variants. By limiting viral spread, vaccination also minimizes opportunities for the introduction of more infectious variants through random mutation. Mutations could produce future variants that are more virulent and capable of evading diagnostic and therapeutic tools or overcoming vaccine-induced immunity.

COVID-19 vaccination coverage at skilled nursing facilities (SNF) helps prevent infection: Nursing home residents have been severely impacted by COVID-19 and are disproportionately represented in overall burden of COVID-19-related morbidity and mortality in the United States. While there has been significant progress in vaccinating SNF residents, vaccination coverage of staff at many facilities remains low. Preliminary data from CDC's National Healthcare Safety Network (NHSN) indicate residents of SNFs in which vaccination coverage of staff is 75% or lower experience higher crude rates of preventable COVID infection.

COVID-19 in Residents of CMS-Certified Skilled Nursing Facilities

Crude Rate per 1,000 Resident Weeks, Stratified by Vaccination Coverage of Staff

Data from the two weeks ending 11 July 2021

Quartile of Staff Vaccination Coverage (percentile)	Staff Vaccination Coverage	Crude Rate of COVID in Residents per 1,000 Resident-weeks, for the two weeks ending 11 July
1 (0th-25th)	0-44%	0.77
2 (26th-50th)	45-59%	0.54
3 (51st-75th)	60-74%	0.26
4 (76th-100th)	75+%	0.31
Overall, national		0.4

Highly significant reductions in incidence between these strata, $P<0.0001$

Reduction between these strata not significant

- There was a 29% significant reduction in the case rate from Q1 to Q2 of staff vaccination coverage
- There was a 52% significant reduction in the case rate from Q2 to Q3 of staff vaccination coverage

Data limited to facilities reporting vaccination coverage.

NHSN NATIONAL HEALTHCARE SAFETY NETWORK

CDC recommends urgent action by all: CDC recommends continued efforts to accelerate primary vaccination efforts, especially in areas with lower vaccination coverage. Individuals who are not fully vaccinated need to maintain all recommended prevention measures. People who are immunocompromised should be counseled about the potential for reduced immune responses to COVID-19 vaccines and to follow current prevention measures to protect themselves against COVID-19 until advised otherwise by their healthcare provider. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits (see vaccine equity resources below).

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination. Co-lead the conversation by participating in community education and outreach events.
- Leverage resources to promote vaccine equity.
- Encourage clinicians to offer and recommend COVID-19 vaccination to their patients and community members.
- Work with community partners to make vaccination easily accessible for unvaccinated populations.
- Implement additional prevention strategies when transmission is high and vaccination coverage is low (*MMWR*).
- Continue to monitor community transmission levels, variant, and vaccination coverage levels, and focus vaccine efforts on populations with low coverage.
- Communicate vaccination coverage, variant, and transmission levels to key partners, including the key information on risk associated with the B.1.617.2 (Delta) variant.

Recommendations for Clinicians

- If you are a clinical provider and are not fully vaccinated, get vaccinated as soon as possible to protect yourself, your family, and your patients.
- Increase patient outreach efforts to encourage, recommend, and offer COVID-19 vaccination.
- Remind patients that vaccination is recommended for all persons aged 12 years of age and older, even for those with prior SARS-CoV-2 infection. Follow trusted sources carefully for any new recommendations and changes in vaccine guidance.
- Support efforts to ensure people receiving a first dose of a COVID-19 mRNA vaccine (i.e., Pfizer-BioNTech or Moderna) return for their second dose to complete the series.
- Communicate with unvaccinated staff, patients, and other individuals to increase confidence in vaccination. CDC has many resources for providers to help increase vaccine confidence .
- Recommend that fully vaccinated patients who are immunocompromised continue to practice all recommended prevention measures for unvaccinated persons.

prevention measures for unvaccinated persons.

Recommendations for Healthcare Facilities and Systems, Nursing Homes, and Businesses

- Recommend and offer COVID-19 vaccine to your staff and employees and establish policies to encourage uptake such as time off to receive the vaccine.
- Consider offering COVID-19 vaccine at your workplace (Workplace COVID-19 Vaccine Toolkit).
- Evaluate whether your facility can implement vaccine requirements or vaccine incentives.

For More Information

- CDC Weekly *Morbidity and Mortality Weekly Report* (*MMWR)* Guidance for Implementing COVID-19 Prevention Strategies in the Context of Varying Community Transmission Levels and Vaccination Coverage
- Interim Public Health Recommendations for Fully Vaccinated People
- COVID Data Tracker

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national and international organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HAN Message Types

- **Health Alert:** Conveys the highest level of importance; warrants immediate action or attention.
- **Health Advisory:** Provides important information for a specific incident or situation; may not require immediate action.
- **Health Update:** Provides updated information regarding an incident or situation; unlikely to require immediate action.
- **Info Service:** Provides general information that is not necessarily considered to be of an emergent nature.

###

This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations.

###

Top of Page

Additional Resources

- HAN Archive By Year
- HAN Types
- Sign Up for HAN Email Updates
- HAN Jurisdictions

Page last reviewed: June 10, 2021

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFFREY M. WHITE

COVID-19 Vaccines That Require 2 Shots

EXHIBIT A-10

Centers for Disease Control and Prevention

COVID-19

COVID-19 Vaccines That Require 2 Shots

Updated Oct. 18, 2021 Print

NOTICE: CDC now recommends that children between the ages of 5 and 11 years receive the Pfizer-BioNTech pediatric COVID-19 Vaccine. Learn more about vaccines for children and teens.

Learn more about who is eligible for a COVID-19 booster shot.

What You Need to Know

- If you receive a Pfizer-BioNTech or Moderna COVID-19 vaccine, you will need 2 shots to get the most protection.
- **COVID-19 vaccines are not interchangeable.** If you received a Pfizer-BioNTech or Moderna COVID-19 vaccine, you should get the same product for your second shot.
- **You should get your second shot even if you have side effects after the first shot**, unless a vaccination provider or your doctor tells you not to get it.
- If you have a weakened immune system due to other diseases or medications, you can receive a COVID-19 vaccine if you have not had a severe or immediate allergic reaction to any of the ingredients in the vaccine.
- People with moderately to severely compromised immune systems should receive an additional dose of mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech or Moderna) after the initial 2 doses.
- Certain groups of people who received both doses of the Pfizer-BioNTech COVID-19 Vaccine are eligible to get a Pfizer-BioNTech booster shot.

Timing of Your Second Shot

The timing between your first and second shots depends on which vaccine you received. If you received the:

Pfizer-BioNTech COVID-19 vaccine
Get your second shot **3 weeks (or 21 days)** after your first

Moderna COVID-19 vaccine
Get your second shot **4 weeks (or 28 days)** after your first

You should **get your second shot as close to the recommended 3-week or 4-week interval as possible**. However, your second dose may be given up to 6 weeks (42 days) after the first dose, if necessary. You should not get the second dose early. There is currently limited information on the effectiveness of receiving your second shot earlier than recommended or later than 6 weeks after the first shot.

However, if you do receive your second shot of COVID-19 vaccine up to 4 days before or at any time after the recommended date, you do not have to restart the vaccine series, and you can be considered fully vaccinated. This guidance might be updated as more information becomes available.

Scheduling Your Second Shot

- Planning for your second shot is important.
- If you need help scheduling your vaccination appointment for your second shot, contact the location that set up your first appointment.
- If you are having trouble or have questions about using a vaccination management or scheduling system, reach out to the organization that enrolled you in the system. This may be your state or local health department, employer, or vaccination provider.
- Scheduling an appointment for your second shot at the time you get your first shot is recommended, but not required.
- If you need to get your second shot in a location that is different from where you received your first shot (for example, if you moved to a different state or attend school in a different state), there are several ways you can find a vaccine provider for your second dose.

Your CDC COVID-19 Vaccination Record Card and Your Second Shot

At your first vaccination appointment, you should have received a CDC COVID-19 Vaccination Record card that tells you what COVID-19 vaccine you received, the date you received it, and where you received it.

- **Bring your vaccination card with you to your second shot appointment** so your provider can fill in the information about your second dose.
- If you did not receive a CDC COVID-19 Vaccination Record card at your first appointment, contact the vaccination provider site where you got your first shot or your state health department to find out how you can get a card.

Learn more about what to do if you need a copy of your CDC COVID-19 Vaccination Record card.

After Getting Your Second Shot

You may experience side effects after getting a COVID-19 vaccine. These are normal signs that your body is building protection. Get helpful tips on how to reduce any pain or discomfort.

Cases of myocarditis and pericarditis in adolescents and young adults have been reported more often after getting the second dose than after the first dose of one of the two mRNA COVID-19 vaccines, Pfizer-BioNTech or Moderna. **These reports are rare and the known and potential benefits of COVID-19 vaccination outweigh the known and potential risks, including the possible risk of myocarditis or pericarditis.**

Use **v-safe** on your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. If you enter your second shot in your **v-safe** account, the system will send you daily health check-ins. Please note that **v-safe** is not automatically notified when you receive a second shot of vaccine, so you must enter the information yourself.

When You Are Fully Vaccinated

People are considered fully vaccinated:

- 2 weeks after their second shot in a 2-dose series, like the Pfizer-BioNTech or Moderna vaccines, or
- 2 weeks after a single-shot vaccine, like Johnson & Johnson's Janssen COVID-19 Vaccine

COVID-19 vaccines are not interchangeable. If you received a Pfizer-BioNTech or Moderna COVID-19 vaccine, you should get the same product for your second shot.

You are **not** fully vaccinated if:

- it has been less than 2 weeks since your 1-dose shot
- it has been less than 2 weeks since your second shot of a 2-dose vaccine
- you still need to get your second dose of a 2-dose vaccine

you still need to get your second dose of a 2-dose vaccine

Booster shots are now available to specific groups of people. However, everyone is still considered fully vaccinated two weeks after their second dose in a 2-shot series, such as the Pfizer-BioNTech or Moderna vaccines, or two weeks after a single-dose vaccine, such as the J&J/Janssen vaccine.

Related Pages

- When Getting Your Vaccine
- Types of Vaccines Available
- Possible Side Effects

Last Updated Oct. 18, 2021

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
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Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JONATHAN BAILEY

EXHIBIT B

DECLARATION OF JONATHAN BAILEY

1. My name is Jonathan Bailey. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as CEO for Hansford County Hospital District since 2010.

3. My responsibilities in that position include:

- Managing our hospital workforce of physicians, nurses, respiratory therapists, and others to meet the health care needs of our community in our hospital, nursing home, outpatient clinics, and EMS.
- Overseeing the finances and operations of the entities comprising Hansford County Hospital District.
- Ensuring compliance with all state and federal laws and regulations.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule requires hospitals, nursing homes, and other health care facilities that want to maintain participation in the Medicare and Medicaid programs to establish a policy to ensure that all eligible staff receive at least one dose of a COVID-19 vaccine by Dec. 6, 2021, and to be fully vaccinated by Jan. 4, 2022.

5. Medicare and Medicaid constitute 45% percent of our revenue. We cannot operate if we do not participate in these two programs, and everyone in our community would lose access to emergency, inpatient, primary, preventive, specialty, and nursing home care if we cease to exist. Since the availability of the COVID-19 vaccines in

December 2020, we have encouraged our staff and community to be vaccinated. We began vaccinating nursing home residents and staff on Dec. 23, 2020.

COVID-19 had a devastating impact on our rural community, and my staff worked tirelessly for months to provide testing, field questions, man a 24/7 hotline, provide accurate information, as well as provide inpatient care around-the-clock care for those with severe COVID-19 infection. My team worked double shifts, isolated from their families, and went weeks without a break. In the worst days of the pandemic, we had as many as 20 hospitalizations at once and converted nursing home beds to inpatient beds to meet the need for care.

Today, about 56% percent of my staff is fully vaccinated against COVID-19. I and my medical and nursing directors work daily to encourage those remaining to get vaccinated. Their reasons for not getting vaccinated are varied and include personal, religious, and medical concerns and objections.

The pandemic's toll on Hansford County Hospital District also includes loss of staff. 20 employees, including 5 nurses, have retired or resigned since March 2020, most of whom did so because of anxiety, frustration, and exhaustion. I cannot afford to lose more staff. Even before the pandemic, we had major challenges recruiting and retaining physicians, nurses, and other clinical staff to our community as we cannot compete with salaries and quality of life offered in larger facilities in more populated areas. Today, those challenges are even more acute. While I recognize and understand the urgency of increasing vaccination rates and will continue to encourage it, I have deep reservations about this mandate because my health care facilities will lose compassionate, experienced, and loyal

staff who took care of our community amid unprecedented challenges. Everyone in our community will suffer if we lose staff and services.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Jonathan Bailey

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
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Plaintiffs,	§	
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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF ERIC BENTLEY

EXHIBIT C

DECLARATION OF ERIC BENTLEY

My name is Eric Bentley, and I am over the age of 18 and fully competent in all respects to make this declaration. I have personal knowledge and expertise of the matters herein stated.

1. I am the Vice Chancellor and General Counsel of the Texas Tech University System ("TTUS") and have been in my current position since September of 2018. In this capacity, I oversee the legal matters for TTUS and its five component institutions: Texas Tech University ("TTU"), Texas Tech University Health Sciences Center ("TTUHSC"), Texas Tech University Health Sciences Center El Paso ("TTUHSC EP"), Angelo State University ("ASU"), and Midwestern State University ("MSU") (hereinafter collectively referred to as "TTUS").

2. On November 5, 2021, the Centers for Medicare and Medicaid ("CMS") released a new Interim Final Rule that requires certain healthcare staff at facilities that participate in the Medicare and Medicaid programs to receive the COVID-19 vaccination ("CMS Vaccination Mandate").

3. TTUHSC has one Federally Qualified Health Center ("FQHC") with three total locations that are likely subject to the CMS Vaccination Mandate.

4. Partner hospitals, including TTUHSC's teaching hospital, the University Medical Center ("UMC"), have begun imposing the CMS Vaccination Mandate on faculty, staff, and students across component institutions within TTUS.

5. If students, residents, or fellows do not agree to comply with the requirements implemented pursuant to the CMS Vaccination Mandate, they may not be able to go to a particular rotation site, participate in clinical experience and/or receive credit for graduation or advancement.

6. All the facts and information contained within this declaration are within my personal knowledge and are true and correct.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 14th day of November 2021.

ERIC BENTLEY

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JENNIFER BRIDGES

EXHIBIT D

DECLARATION OF JENNIFER BRIDGES

1. My name is Jennifer Bridges. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I am a registered nurse that had been working for Houston Methodist Baytown for 8 years in their medical/surgical department 2-West. I worked on this inpatient unit caring for patients with many various conditions. During the covid surge I also worked on the Covid unit for several months.

3. The entire time I was with the company, there was always a nursing shortage. Nurses were constantly getting floated to other units to assist. It was extremely rare to come to work and be fully staffed. You would be sent to other units that you were not properly trained on when needed. It was very stressful to be thrown into these situations. Especially during the Covid surge, there was a huge shortage of nurses. This was due to the demand and also the fact that nurses were constantly having to miss work due to contracting Covid themselves.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule forces me to receive the EUA Covid shot against my will in order to keep employment.

5. There is absolutely no reason I should take this injection because I contracted Covid from a patient over a year ago. I have natural immunity and my antibodies are still very high. Natural immunity has always proven to be very effective and more adequate

than a manmade shot. I have also seen many adverse reactions due to the Covid shot and the risks are far greater for me than the virus itself.

6. Houston Methodist mandated the Covid shot on June7, 2021. I was not comfortable injecting this into my body and they were not willing to compromise to accommodate my decision to my own bodily autonomy. As a result, I was suspended without pay for 2 weeks and officially terminated on June 22, 2021. I was forced out of my career which I had planned to retire from, simply because my employer did not respect my own personal choices and the science behind natural immunity.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Jennifer Bridges

Jennifer Bridges

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
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Plaintiffs,	§	
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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF PIERRE CHARLAND

EXHIBIT E

DECLARATION OF PIERRE CHARLAND

1. My name is Pierre Charland I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I currently work for a medical device company so I don't have any patient care responsibilities. I can't be hired by a hospital to help alleviate the nursing shortage because I did not receive any of the Covid vaccination.

3. I have worked in the past with patients as an ICU nurse and nursing shortages make the situation bad for everyone. It hurts the patients because they don't get the attention they need; surgeries are canceled because of a lack of bed and it can burn out staff. People can and will die due to nursing shortage.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule would prevent me from going back to work in a hospital and provide patients care. I was terminated from Houston Methodist last June for not having the Covid vaccine.

5. I do not wish to receive any of the currently available covid vaccines because they are not safe. According to VAERS report, thousands have been killed and many more have suffered adverse reactions from tinnitus to stroke and many others. The vaccines do not prevent infection and transmission. This fact has been acknowledged by the CDC and they are still asking the vaccinated to wear a mask which means they don't have confidence in the vaccines.

6. I have already been terminated from a job in June 2021 for not getting vaccinated. I don't plan taking the vaccine if my current employer gives me the same ultimatum. My former employer denied my religious exemption, the present one approved it. I would not get any of these vaccines because they are not safe and effective.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Pierre Charland RN

Pierre Charland

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
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Plaintiffs,	§	
	§	
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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF MICHELLE DIONNE-VAHALIK

EXHIBIT F

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; MEENA SESHAMANI, in her official capacity as Deputy Administrator and Director of Center for Medicare; DANIEL TSAI, in his official capacity as Deputy Administrator and Director of Medicaid and CHIP Services; THE CENTERS FOR MEDICARE & MEDICAID SERVICES; JOSEPH R. BIDEN, in his official capacity as President of the United States; UNITED STATES OF AMERICA;	§	Case No. _____
	§	
Defendants.	§	

DECLARATION OF MICHELLE DIONNE-VAHALIK

1. My name is Michelle Dionne-Vahalik. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as Associate Commissioner of Long-Term Care Regulation for the Texas Health and Human Services Commission (HHSC) since March 2020.

3. My responsibilities in that position include oversight of all operations within the Long-term Care Regulation Department. This includes the oversight of survey and investigation activities to determine minimal compliance for approximately 12,000 providers who deliver long term care services and support.

4. I am aware of the Interim Final Rule ("IFR") issued by CMS on November 5, 2021. Generally, I understand the IFR to require Medicaid-certified providers and suppliers regulated by CMS to develop and implement policies and procedures to ensure staff are vaccinated for COVID-19 and that documentation of those vaccinations is tracked and maintained. Unlike the OSHA rule, CMS provides no alternative to vaccination (such as regular COVID-19 testing and or face coverings) and allows exemptions only to the extent necessary to comply with laws protecting religious freedom or medical conditions. The IFR therefore compels the impacted regulated provider to either terminate its unvaccinated employees or risk losing Medicaid funding. The Long-Term Care Regulated Providers that fall under the CMS mandate are Nursing Facilities, Intermediate Care Facilities, Home Health Agencies, and Hospice Agencies. For Long Term Care Regulation this is approximately 4,779 health care providers.

5. In the Long-Term Care Regulation Division, we oversee and enforce regulatory compliance of several categories of Medicaid-certified providers that are subject to the IFR including Nursing Facilities, Intermediate Care Facilities for those with Intellectual Disabilities, Home Health Agencies, and Hospice Agencies. Pursuant to state and federal regulations, each long-term care facility is required to meet established minimum standards to ensure the health and safety of the individuals receiving services. Further, each facility is required to provide

sufficient staff, at all times, to guarantee these standards are being met.

6. Based upon my experience and conversations with providers at these various facilities, hiring, retaining competent and qualified staff is difficult and has been for many years. The public health emergency caused by the COVID-19 pandemic exacerbated these staffing issues and worsened the staffing shortage.

7. Staff at regulated facilities that are subject to the IFR will be impacted by the federal requirements. Decreased staffing at these facilities increases the likelihood that the provider will be unable to satisfy minimum standards and comply with all applicable regulations. Moreover, failing to meet minimum standards and applicable regulations increases the likelihood of harm to the individuals served and will result in enforcement actions, exacerbating an already difficult situation.

8. CMS has expressed an expectation that state agencies will conduct onsite compliance reviews of the vaccination requirements via standard recertification surveys as well as an assessment of vaccination status of staff on all complaint surveys. HHSC is already experiencing a critical shortage of surveyors and dealing with an unprecedented backlog of complaints and recertification visits. The IFR will require additional surveyor time onsite and any further reduction in staff increases the risks to patient health and safety.

9. HHSC has also been advised that the vaccine mandate will also apply to surveyors who survey these entities. Long Term Care Regulation is experiencing unprecedented turnover to survey staff due to COVID 19 and heavy workload. If we have to remove survey staff due to lack of vaccination from surveying these providers on-site it will lead to greater backlog and delays in on-site inspections and investigations. This places us at risk of meeting our primary mission which is protecting the health and safety of individuals receiving care and services from those we regulate. The impact is to approximately 450 front line survey staff and another 100 managers that also enter these regulated providers to assist survey staff and or to supervise them.

10. We also anticipate an increased workload requiring additional resources to implement and enforce new requirements.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 12 2021.

Michelle Dionne-Vahalik

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
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	§	
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APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF STARLA HAUGENATER

EXHIBIT G

DECLARATION OF STARLA HAUGENATER

1. My name is Starla Haugenater. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I am an RN, BSN prepared nurse, who was working for Houston Methodist Baytown Hospital. I was employed by Houston Methodist from July 2009 to July 2021. My position was Charge Nurse of the Interventional Radiology department prior to termination. I also worked on a Medical-Surgical unit, as well as the Observation unit.

3. I, on a number of occasions, experienced staffing shortages while working as a nurse on the floor, providing direct patient care. I frequently worked in a 6:1 ratio, 6 patients for 1 nurse. In my most recent role as the charge nurse for Interventional Radiology, I was responsible for scheduling registered nurses for our department, and often times would work short staffed, as we would have to seek help from the float pool to ensure coverage for the daily patient load. Prior to termination, I proposed to my manager and director about inquiring within Administration, to seek nurses who would be put on call or canceled throughout the hospital related to low census, to help in our department to relieve staffing shortages. This was not finalized prior to my termination.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule requires health care personnel to be vaccinated against various illnesses, for the protection of patients, visitors and staff.

5. I choose not be vaccinated, because I personally have a health condition that is under current observation, and prior to termination I was given a temporary exemption

pending full diagnosis. I was granted this temporary exemption prior to undergoing a full work up by an Autonomic specialist in Dallas, TX. The reason given by my Cardiologist, was that many of the symptoms I experience daily could not be differentiated between the COVID-19 vaccine potential reactions and autonomic dysfunction. Should an adverse reaction occur, it could potentially exacerbate my condition, or worse. I have chosen to take the necessary precautions to protect myself and others by observing all measures to prevent contraction or transmission of the virus. I feel that this is the most effective way to protect the health of myself and others, as well as sustain some sort of quality of life with my condition.

6. I chose to leave my position at Houston Methodist Baytown, because I did not feel that the forced COVID-19 vaccination was a "one size fits all" solution. There are unique health conditions and personal situations that must be taken into account. In my particular situation, I feel that the risk of potential side effects far outweigh the benefits of the vaccine. Quality of life is something that only a person can measure for themselves. Having an employer deem what is an appropriate safety measure for my personal health, regardless of the potential side effects, does not seem just. Who would be liable for my personal suffering or death, if I chose the risk?

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Starla M. Haugenater, RN, BSN

Starla M. Haugenater, RN, BSN

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
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Plaintiffs,	§	
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v.	§	Case No. 2:21-CV-00229-Z
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	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF KRISTI JORDAN

EXHIBIT H

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, Plaintiffs, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; MEENA SESHAMANI, in her official capacity as Deputy Administrator and Director of Center for Medicare; DANIEL TSAI, in his official capacity as Deputy Administrator and Director of Medicaid and CHIP Services; THE CENTERS FOR MEDICARE & MEDICAID SERVICES; JOSEPH R. BIDEN, in his official capacity as President of the United States; UNITED STATES OF AMERICA; Defendants.	§ §	Case No. _________

DECLARATION OF KRISTI JORDAN

1. My name is Kristi Jordan. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as Associate Commissioner for Health Care Regulation (HCR), Regulatory Services Division, for the Texas Health and Human Services Commission (HHSC) since September 1, 2017.

3. My responsibilities in that position include managing the staff who regulate acute health care facilities to protect consumer and patient health and safety by ensuring compliance with state and federal laws and rules. Regulatory activities include surveying acute care facilities, reviewing complaints, investigating possible violations, evaluating evidence, and reviewing plans of correction. In accordance with Texas law, HCR also establishes rules and standards for acute care facilities' general operations, patient services, and physical plants, as well as procedural rules regarding license applications and issuance, complaints, and violations. Texas law requires certain types of health care facilities to be licensed in order to provide services. The licensing procedure varies according to facility type and may include application review, fees, architectural and life safety code approval, and initial on-site surveys.

4. I am aware of the Interim Final Rule ("IFR") issued by CMS on November 5, 2021. Generally, I understand the IFR to require Medicare-certified providers and suppliers regulated by CMS to develop and implement policies and procedures to ensure staff are vaccinated for COVID-19 and that documentation of those vaccinations is tracked and maintained.

5. In Health Care Regulation, we oversee and enforce regulatory compliance of the following facilities that will be subject to the IFR: Ambulatory Surgical Centers, Hospitals(including psychiatric hospitals), Comprehensive

Outpatient Rehabilitation Facilities, Critical Access Hospitals, Outpatient Physical Therapy and Speech-language Pathology Services, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and End-Stage Renal Disease Facilities. Of those provider types impacted by the rule, there is a total of approximately 3,108 facilities affected by the IFR statewide. Pursuant to state and federal regulations, each of these facilities is required to meet established minimum standards to ensure the health and safety of the individuals receiving services. Further, each facility is required to provide sufficient staff, at all times, to guarantee these standards are being met.

6. Staff at regulated facilities that are subject to the IFR will be impacted by the federal requirements. Decreased staffing at these facilities increases the likelihood that the provider will be unable to satisfy minimum standards and comply with all applicable regulations. If providers can't meet minimum staffing needs, the health and safety of patients is at risk. Moreover, failing to meet minimum standards and applicable regulations increases the likelihood of harm to the individuals served and will result in enforcement actions, exacerbating an already difficult situation.

7. CMS has expressed an expectation that state agencies will conduct onsite compliance reviews of the vaccination requirements via standard recertification surveys as well as an assessment of vaccination status of staff on all complaint surveys. Therefore, surveyors who are required to enforce the rule will also be impacted. There are approximately 79 Health Care Regulation staff who enter acute care facilities for surveys. If we have to remove staff due to lack

of vaccination from surveying these providers on-site, it could lead to delays of on-site inspections and investigations. This places us at risk at meeting our primary mission, which is protecting the health and safety of individuals receiving care and services from those we regulate.

8. I have been involved in conversations with providers and provider associations wherein they have commented about staffing challenges. The staffing challenges discussed were not specific to a vaccine mandate but were more about the current overall market and the challenge in hiring people. With the IFR we can reasonably expect these staffing challenges will worsen.

9. We also anticipate an increased workload requiring additional resources to implement and enforce new requirements.

10. The IFR further requires health care providers to establish a process or policy to ensure staff, except for those individuals who are granted an exemption, are fully vaccinated over two phases:

- Phase 1: Within 30 days of the rule's publication, or by Dec 6, staff at all health care facilities where the regulation applies must have received their first dose of a 2-shot series (Moderna or Pfizer, currently) or a single dose of a 1-shot vaccine (Johnson and Johnson, currently). Staff must complete this step before they can provide any care, treatment or other services for the facility and/or its patients.
- Phase 2: Within 60 days of the rule's publication, or by Jan 4, all staff must complete the primary vaccination series.

We have concerns about this time frame given that we will have to develop policies and procedures to train staff to track and document vaccination status, to ensure all employees are in compliance.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 15, 2021.

Kristi Jordan Digitally signed by Kristi Jordan
Date: 2021.11.15 10:03:00 -06'00'

Kristi Jordan

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF ROGELIO MENDEZ JR.

EXHIBIT I

DECLARATION OF ROGELIO MENDEZ JR

1. My name is Rogelio Mendez Jr.. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. [I am a Registered Nurse currently working in the Cardiovascular/Cardiothoracic Operating Room at Houston Methodist Hospital (SugarLand, TX). I have been there since 2012.

3. For the first time in the history of my employment, we've seen traveling nurses being brought in to accommodate for the lack of permanent staff. "Since I have been employed there, I have never seen this before."

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule [This rule would force me to receive the COVID 19 vaccine which is completely against my religious belief and my personal choice.

5. I believe God created mankind in a way that would allow people to overcome various infections/diseases without altered cellular activity.

6. If I was forced to received the COVID 19 vaccine then not only would I leave this place of employment, but also potentially the entire field of nursing.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 12, 2021.

Rogelio Mendez Jr. RN/CNOR

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF SARA PIKA

EXHIBIT J

DECLARATION OF SARA PIKA

My name is Sara Pika. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

I worked for Houston Methodist Willowbrook as the Antepartum/Postpartum Nurse Manager from January 2020 until April 29, 2021, when I was relieved of my position due to declining the COVID vaccine. I was the first manager ever fired for refusal to take the vaccine in the United States. Houston Methodist denied both my medical and religious exemptions, and my employment was terminated. As a nurse manager, I was in an administrative position. However, when staffing needs arose, I would put on my scrubs and provide direct patient care. My unit was used to cohort and care for pregnant COVID+ patients during all COVID surges in the Houston area. After being relieved of my professional responsibilities at Houston Methodist Willowbrook, I searched for another position. I am now working full-time at HCA Tomball as a Postpartum nurse providing direct patient care at the bedside. I began this new position in August 2021.

Staffing is a long-standing issue in the nursing profession. Since the onset of COVID, I have witnessed an exponential number of "Baby Boomers" choose early retirement instead of complying with the ever-changing demands of healthcare for the past nearly two years. Nursing is already a challenging profession. Caring for people when they are at their worst is physically and mentally exhausting. We put others' needs before our own daily. Many nurses don't have time to empty their bladder or fill their belly during their 12, sometimes 16, hour shifts. I worked alongside my team through COVID, Hurricane Laura, and the polar vortex, which resulted in a monumental Texas Freeze and subsequent loss of power. I spent the night at the hospital with my team, caring for our patients and meeting their every need. At the same time, my husband was left to care for our own family with small children alone. I was abandoning my family to care for another's loved ones. When coupled with the increased demands of COVID, administration, and even more significant staffing shortages, many nurses chose to retire early. Nurses nowhere near retirement have chosen to stay home and provide stability for their families, avoiding the chaos of the inpatient hospital settings and the ever-changing, unrealistic demands of hospital upper-leadership and our government officials. I have not seen nursing shortages to this extent thus far in my 17-year career in the acute care setting. I have witnessed managers in staffing on practically a daily basis in at least one unit, but often multiple units throughout the hospital, to make ends meet. One manager at Houston Methodist worked five consecutive night shifts due to not having enough staff to meet patient needs. Numerous managers put themselves into their staffing numbers, flipping from dayshift to nightshift, as there was no one else to meet the staffing needs. All while hospital administrators were calling meetings to discuss HCAHPS scores that were not meeting their prearranged goal and demanding to know the managers' action plan to rectify said scores. This is incomprehensible. It demonstrates the utter disconnect between bedside care and the C-suite.

I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule requires me to receive the COVID-19 vaccine.

I will not be taking the COVID-19 vaccine, as I contracted COVID and tested positive on December 22, 2020. I was ill but recovered and returned to the hospital, caring for my staff and patients. Due to contracting the virus and healing, I have natural antibodies, protecting myself from the virus. "It is true that natural infection almost always causes better immunity than vaccines. Whereas immunity from disease often follows a single natural infection, immunity from vaccines usually occurs only after several doses. However, the difference between vaccination and natural infection is the price paid for immunity: The price paid for immunity after natural infection might be pneumonia from chickenpox, intellectual disability from Haemophilus influenzae type b (Hib), pneumonia from pneumococcus, birth defects from rubella, liver cancer from hepatitis B virus, or death from measles. Immunization with vaccines, like natural infections, typically induces long-lived immunity. But unlike natural infection, immunization does not extract such a high price for immunity; that is, immunization does not cause pneumonia, intellectual disability, birth defects, cancer or death." (Vaccine Safety: Immune System and Health | Children's Hospital of Philadelphia, 2021). I have already endured the natural infection and recovered, creating protective antibodies.

The COVID-19 vaccination violates my firmly held religious beliefs. The COVID-19 vaccines used aborted fetal cell lines during vaccine testing, research and development, and production. Abortion is taking a life- synonyms: killing, murder. As one of the 10 commandments listed in the Bible, God commanded, "Thou shalt not kill," Exodus 20:13. Abortion is in direct opposition to this commandment by God Almighty. God did not differentiate based on age or time. He said, "Do not kill." God is the creator of life. Only He can create life, and only He can end it; He sees all. "For you created my inmost being; you knit me together in my mother's womb…My frame was not hidden from you when I was made in the secret place" Psalm 139:13, 15. By taking this vaccine, I would be disobeying this command directly from God to protect life, not take it, while indirectly supporting and promoting abortion, which goes against my firmly held religious beliefs. The Bible states, "Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore, honor God with your bodies" 1 Corinthians 6:19-20. I firmly believe that by taking the COVID vaccine, I am deliberately disobeying God and capitulating on my dearly held religious beliefs. Webster defines disobedience as "refusal or neglect to obey." Disobedience is defiance for selfish gain; it is a sin. As a Christian, I believe that my life and body are a gift from God that I am lent while on this earth, yet they do not belong to me; they belong to God. Each day I'm on this earth, and every breath I take is a gift from my Father in Heaven. Only God the Father knows how many days I will be on this earth. He knew the total number of days I would live before I was ever conceived. "Your eyes saw my unformed body; all the days ordained for me were written in your book before one of them came to be" Psalm 139:16. One day, I will stand before the

judgment seat of Christ, and I alone will be held accountable for my actions, or lack thereof. Colossians 3:23, "Whatever you do, work at it with all your heart, as working for the Lord, not for human masters." I choose absolute obedience to my Lord and Savior Jesus Christ over obedience to any human master on this earth.

Due to my sincerely held religious beliefs, I submitted a religious exemption. I suffer from severe allergies and asthma- a reactive airway disease. Therefore, in addition to my religious exemption, I submitted a medical exemption from a provider recommending against receiving the COVID-19 vaccine. BOTH of my exemptions were denied by Houston Methodist. My director and the ACNO pulled me into their office on separate occasions to discuss why I was not receiving the vaccine. My healthcare choices are mine alone to decide. I felt vulnerable and highly pressured to accept the COVID-19 vaccine. I refused to capitulate on my religious beliefs, so I was placed on a 2-week unpaid suspension on April 15, 2021, and Houston Methodist terminated my employment on April 29, 2021. If this ridiculous mandate was not in effect, I would still be working in my previous position. I did not choose to leave; my employment was terminated out from underneath me.

I began working part-time at age 15. I have worked full-time since I was 18-years-old, which is 18 years and counting, as I am a 36-year-old married mother of 5 children. In my 21 years of employment, I have never received any form of disciplinary action. I am a high-performer who strives to do my best daily. I am my own biggest competition. I push myself to do better every day. I have a family who depends on my contribution to make ends meet at home. Houston Methodist ending my employment with short notice and zero compromise or compassion was an attempt to force staff into complying with their vaccine mandate, which is unconstitutional.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Sara Pika

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF SCOTT SCHALCHLIN

EXHIBIT K

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare & Medicaid Services; MEENA SESHAMANI, in her official capacity as Deputy Administrator and Director of Center for Medicare; DANIEL TSAI, in his official capacity as Deputy Administrator and Director of Medicaid and CHIP Services; THE CENTERS FOR MEDICARE & MEDICAID SERVICES; JOSEPH R. BIDEN, in his official capacity as President of the United States; UNITED STATES OF AMERICA;	§	Case No. _____
	§	
Defendants.	§	

DECLARATION OF SCOTT SCHALCHLIN

1. My name is Scott Schalchlin. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as Deputy Executive Commissioner for the Health and Specialty Care System for the Texas Health and Human Services Commission since August 2021. Prior to

that I served as the Associate Commissioner for the State Supported Living Centers (SSLCs) for almost 8 years.

3. My responsibilities in this position include oversight of all operations for the thirteen SSLCs, nine State Hospitals (SHs) and one residential youth center for individuals with mental health issues. These facilities serve individuals with intellectual disabilities or mental health and psychiatric needs.

4. The State Supported Living Centers are certified as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD). They provide campus-based direct services and support to people with intellectual and developmental disabilities at 13 locations. They serve people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems. Their current census is 2,700. The Center for Medicare and Medicaid Services (CMS) requires the SSLCs to meet the conditions of participation of the program in order to maintain their certification. The ICF/IID program is a Medicaid program funded through state and federal dollars, in which the federal portion is determined by the Federal Medical Percentage (FMAP). For FY21, the FMAP was 61.81% (but there was also an enhanced FMAP through APRA), taking the total federal funds received by the SSLCs to $515 million.

5. The State Hospitals provide both forensic and non-forensic psychiatric care to thousands of Texans with mental illness throughout the state. Their current census is 1,560, although they have over 600 beds offline due to the inability to hire and retain adequate staffing levels. Largely funded by the state, they also comply with certain CMS requirements, which allows them to bill for services if a patient is Medicaid or Medicare eligible. In FY21, the state

received approximately $956,000 in revenue though the FMAP and IMD (Medicaid). The state also received $24.6 million through Medicare billing.

6. The Health and Specialty Care System has historically experienced problems with low fill rates and high turnover rates in key staffing areas. However, since the beginning of the public health emergency in March 2020, this problem has been exacerbated. Fill rates for the Health and Specialty Care System have dropped steadily from 86% in March 2020 to 73% in September 2021. Staffing challenges have strained the Health and Specialty Care System and made daily operations more challenging. For example, the SHs have 8,508 FTEs, of which only 6,351 positions are filled. The SSLCs have 13,863 FTEs, of which 9945 are filled.

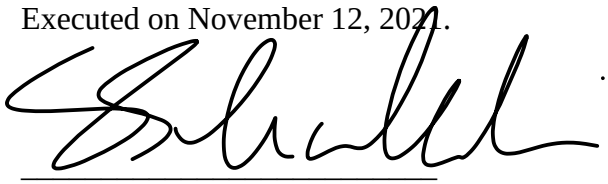
7. I am aware of the CMS Omnibus Healthcare Staff Vaccination Rule promulgated on November 5, 2021 and generally I understand that it will require the Health and Specialty Care System to develop, implement and enforce a mandatory COVID-19 vaccination policy with limited opportunity for staff to refuse vaccination.

8. Staffing levels in Health and Specialty Care facilities will be impacted by this federal requirement. Many staff have expressed their opposition to mandatory vaccines and I anticipate that some staff will resign in lieu of compliance with this requirement. Decreased staffing will increase the likelihood of injury or incident, could require halting of admissions to HSCS facilities, lead to closure of beds or units in the state hospitals, expand the civil and forensic inpatient care waitlists for state hospitals, and increase the likelihood of regulatory citation due to sub-minimal staffing levels. The downstream impacts of these events will likely lead to increased pressure on local mental health systems, county jails, and the court system as well.

9. Additionally, I also anticipate an increased workload requiring additional resources required to implement and enforce new requirements.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 12, 2021.



Scott Schalchlin

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF KARA SHEPHERD

EXHIBIT L

DECLARATION OF KARA SHEPHERD

1. My name is Kara Shepherd. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I worked as a Labor & Delivery Nurse at Houston Methodist Willowbrook Hospital for 7 years and 8 months. I was a charge nurse for the unit, I took care of mom's during antepartum, intrapartum and postpartum. I circulated C-Sections in the OR, transitioned infants after delivery and worked in the OB Emergency Department.

3. I was a charge nurse for several of the years I worked at Houston Methodist, there were times that our staffing was so short that I would have to take patients, this wasn't safe because I was also in charge of making sure all the patients on the floor for taken care of and that things were running smoothly. Our OB Emergency Department was supposed to ALWAYS have two nurses in it, several times as Charge I would have to pull one of the nurses out to the floor to care for patients because we didn't have enough staff. A lot of the time nurses were required to take assignments that were unsafe, high acuity patients were required to be one-on-one, but had to be doubled because of lack of staff.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule. If I had not been fired from my job for not taking the vaccination because of a mandate put in place by Houston Methodist, this rule would also lead me to be terminated because I didn't want the shot.

5. I do not believe this "vaccine" is safe, it has not been put through the proper trials, ADE (Antibody Dependent Enhancement) that is what happens when you take the

shot. In previous studies the animals that were vaccinated either became sicker after vaccination or died. I have had COVID and I now have natural immunity and I believe that is far better than what any vaccine can do for you.

6. I chose to stand up for myself and make a choice, I believe in freedom. I do not think I should have to have a vaccine as a condition of employment. I did not have a choice, I was terminated because I would take this COVID shot.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Kara Shepherd RN

Kara Shepherd

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF JEFF R. TURNER, MSHA, FACHE

EXHIBIT M

DECLARATION OF JEFF R. TURNER, MSHA, FACHE

1. My name is Jeff R. Turner. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as Chief Executive Officer for Moore County Hospital District since 2008.

3. My responsibilities in that position include administrative oversight to all aspects of the hospital district which is located in Dumas, Moore County, Texas.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule mandates covid vaccinations for healthcare workers with the threat of termination for the employee and financial penalties for employers.

5. Moore County Hospital District ("MCHD") is a critical access hospital district in the north Texas Panhandle that has cared for covid patients since the initial covid surge arrived in March 2020. Moore County was one of the earliest and hardest hit rural communities in Texas as a result of our geographic isolation and the presence of a meat-packing plant with a sizable refugee population. For much of 2020, Moore County held the dubious distinction of having the highest per capita covid-infection rate in Texas.

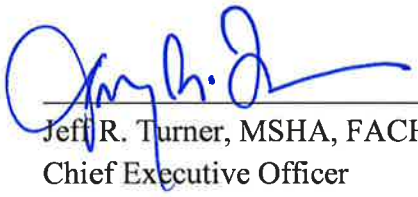
Despite Moore County's covid statistics, 99 of MCHD's 372 full-time equivalent employees remain unvaccinated. Many of these unvaccinated employees are nurses and other clinical staff who directly care(d) for covid-positive patients. Assuming the mandate is fully implemented and these employees remain unvaccinated without qualifying for an exemption, MCHD will have to terminate their employment or face

punitive actions from CMS. Medicare and Medicaid programs comprise 45% of MCHD's total payor mix. Losing this revenue would bankrupt the District. Likewise, losing these employees – even if we lose only 50% of them – will cripple MCHD's ability to fulfill our commitment to provide essential healthcare services that include: EMS, trauma and acute care, surgical and obstetrical services, long-term care, home health and hospice, and physician and outpatient clinical ancillaries.

The Mandate puts rural hospitals in a no-win situation. Either we pay a penalty we cannot afford or we lose staff we cannot replace or afford to lose.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 12, 2021.



Jeff R. Turner, MSHA, FACHE
Chief Executive Officer

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

DECLARATION OF ADAM WILLMANN

EXHIBIT N

DECLARATION OF ADAM WILLMANN

1. My name is ADAM WILLMANN. I am over 18 and competent to make this declaration. The facts in this Declaration are based on my personal knowledge, and I would testify to these facts in open court if called upon to do so.

2. I have served as CHIEF EXECUTIVE OFFICER for GOODALL-WITCHER HEALTHCARE since 2012.

3. My responsibilities in that position include MANAGING GWH'S OVERALL OPERATIONS INCLUDING; IMPLEMENTING POLICIES, MANAGING THE BUDGET, ENSURING THE SAFETY AND QUALITY OF CARE PROVIDED.

4. I am aware of the interim final rule, titled "Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination," promulgated by CMS on November 5, 2021. I understand that the rule REQUIRES THE CREATION OF A POLICY AND ENFORCING THE VACCINE MANDATE REQUIRING EVERY EMPLOYEE TO BE FULLY VACCINATED BY JANUARY 4, 2022. FAILURE TO COMPLY WITH THE CMS VACCINE MANDATE BY INDIVIDUAL EMPLOYEES WILL ULTIMATELY RESULT IN TERMINATION OF EMPLOYMENT.

5. THIS RULE WILL STRAIN AN ALREADY SHORT LABOR STAFF MARKET, CREATING AN UNDUE BURDEN ON PATIENTS AND HEALTHCARE ORGANIZATIONS, INCLUDING GOODALL-WITCHER. I HAVE HAD MULTIPLE EMPLOYEES INFORM ME THAT THEY WOULD BE RESIGNING IF THEY ARE REQUIRED TO GET THE VACCINE. SOME OF THESE STAFF MEMBERS ARE NURSES IN HIGHLY SKILLED AREAS. IF GWH LOSES EVEN A FEW NURSES OR STAFF, SOME SERVICES WILL HAVE TO BE HALTED. DISCONTINUING ANY OF

OUR SERVICES WILL REQUIRE PATIENTS TO TRAVEL LONG DISTANCES TO RECEIVE CARE. ONE PARTICULAR DEPARTMENT IS LABOR AND DELIVERY. IF THESE SERVICES ARE SUSPENDED, SOME PATIENTS WILL HAVE TO TRAVEL 35 MILES OR MORE TO DELIVER THEIR BABY. OUR RURAL REGION DOES NOT CONTAIN INDIVIDUALS WITH THE SKILL SETS TO BACK FILL THE VACATED POSITIONS.

6. OVER THE PAST 10 MONTHS I HAVE STRONGLY ENCOURAGED VACCINATION AND PROVIDED INCENTIVES TO STAFF WHO CHOOSE TO BECOME VACCINATED. THROUGH THESE INITIATIVES WE HAVE BEEN ABLE TO REACH APPROXIMATELY 70% VACCINATION RATE. WE HAVE NOT HAD A MAJOR OUTBREAK OF COVID AMONG OUR STAFF SINCE THE BEGINNING OF THE PANDEMIC. MANY OF OUR STAFF MEMBERS CONTRACTED THE VIRUS DURING THE EARLIER PHASE OF THE PANDEMIC BECAUSE OUR NATIONAL SUPPLY-CHAIN FOR PPE WAS CUT OFF AND NO VACCINE WAS PRESENT AT THAT TIME. WE ARE CONTINUING OUR EFFORTS IN EDUCATING OUR STAFF ON THE FACTS OF THE VACCINE. HOWEVER, FORCING ME TO TERMINATE MY STAFF WHO REFUSE THE VACCINE WILL NOT ENSURE MORE INDIVIDUALS GET THE VACCINE, BUT CREATE A LARGER ISSUE IN PROVIDING NECESSARY AND TIMELY CARE TO THOSE THAT NEED IT THE MOST.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on November 11, 2021.

Adam B. Willmann

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	Case No. 2:21-CV-00229-Z
	§	
XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

EXECUTIVE ORDER NO. GA-40

EXHIBIT O

GOVERNOR GREG ABBOTT

October 11, 2021

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:30PM O'CLOCK
OCT 11 2021
Secretary of State

Mr. Joe A. Esparza
Deputy Secretary of State
State Capitol Room 1E.8
Austin, Texas 78701

Dear Deputy Secretary Esparza:

Pursuant to his powers as Governor of the State of Texas, Greg Abbott has issued the following:

> Executive Order No. GA-40 relating to prohibiting vaccine mandates, subject to legislative action.

The original executive order is attached to this letter of transmittal.

Respectfully submitted,

Gregory S. Davidson
Executive Clerk to the Governor

GSD/gsd

Attachment

Executive Order

BY THE
GOVERNOR OF THE STATE OF TEXAS

Executive Department
Austin, Texas
October 11, 2021

EXECUTIVE ORDER
GA 40

Relating to prohibiting vaccine mandates, subject to legislative action.

WHEREAS, I, Greg Abbott, Governor of Texas, issued a disaster proclamation on March 13, 2020, certifying under Section 418.014 of the Texas Government Code that the novel coronavirus (COVID-19) poses an imminent threat of disaster for all Texas counties; and

WHEREAS, in each subsequent month effective through today, I have renewed the COVID-19 disaster declaration for all Texas counties; and

WHEREAS, I have issued a series of executive orders aimed at protecting the health and safety of Texans, ensuring uniformity throughout Texas, and achieving the least restrictive means of combatting the evolving threat to public health; and

WHEREAS, COVID-19 vaccines are strongly encouraged for those eligible to receive one, but must always be voluntary for Texans; and

WHEREAS, I issued Executive Orders GA-35, GA-38, and GA-39 to prohibit governmental entities and certain others from imposing COVID-19 vaccine mandates or requiring vaccine passports; and

WHEREAS, in yet another instance of federal overreach, the Biden Administration is now bullying many private entities into imposing COVID-19 vaccine mandates, causing workforce disruptions that threaten Texas's continued recovery from the COVID-19 disaster; and

WHEREAS, countless Texans fear losing their livelihoods because they object to receiving a COVID-19 vaccination for reasons of personal conscience, based on a religious belief, or for medical reasons, including prior recovery from COVID-19; and

WHEREAS, through Chapter 161 of the Texas Health and Safety Code, as well as other laws including Chapters 38 and 51 of the Texas Education Code, the legislature has established its primary role over immunizations, and all immunization laws and regulations in Texas stem from the laws established by the legislature; and

WHEREAS, the legislature has taken care to provide exemptions that allow people to opt out of being forced to take a vaccine for reasons of conscience or medical reasons; and

WHEREAS, I am adding this issue to the agenda for the Third Called Session of the legislature that is currently convened so that the legislature has the opportunity to consider this issue through legislation; and

WHEREAS, I will rescind this executive order upon the effective date of such legislation;

FILED IN THE OFFICE OF THE
SECRETARY OF STATE
4:30pm O'CLOCK

OCT 11 2021

NOW, THEREFORE, I, Greg Abbott, Governor of Texas, by virtue of the power and authority vested in me by the Constitution and laws of the State of Texas, do hereby order the following on a statewide basis effective immediately:

1. No entity in Texas can compel receipt of a COVID-19 vaccine by any individual, including an employee or a consumer, who objects to such vaccination for any reason of personal conscience, based on a religious belief, or for medical reasons, including prior recovery from COVID-19. I hereby suspend all relevant statutes to the extent necessary to enforce this prohibition.

2. The maximum fine allowed under Section 418.173 of the Texas Government Code and the State's emergency management plan shall apply to any "failure to comply with" this executive order. Confinement in jail is not an available penalty for violating this executive order.

3. This executive order shall supersede any conflicting order issued by local officials in response to the COVID-19 disaster. Pursuant to Section 418.016(a) of the Texas Government Code, I hereby suspend Sections 418.1015(b) and 418.108 of the Texas Government Code, Chapter 81, Subchapter E of the Texas Health and Safety Code, and any other relevant statutes, to the extent necessary to ensure that local officials do not impose restrictions in response to the COVID-19 disaster that are inconsistent with this executive order.

This executive order does not supersede Executive Orders GA-13, GA-37, GA-38, or GA-39. This executive order shall remain in effect and in full force unless it is modified, amended, rescinded, or superseded by the governor. This executive order may also be amended by proclamation of the governor.

Given under my hand this the 11th day of October, 2021.

GREG ABBOTT
Governor

ATTESTED BY:

JOE A. ESPARZA
Deputy Secretary of State

FILED IN THE OFFICE OF THE SECRETARY OF STATE
4:30pm O'CLOCK
OCT 11 2021