

April 6, 2020

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

Dear Mr. Secretary:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks **the Secretary of Health and Human Services (HHS) to consider additional actions to temporarily suspend certain requirements in order for health care providers to better respond to the novel coronavirus (COVID-19) outbreak.**

Immediately following the President's national emergency declaration, HHS and its agencies took action to implement critical waivers consistent with section 1135 of the Social Security Act for hospitals and health systems across the country. Those initial steps, as well as additional waivers announced on March 30, are already playing a vital role in our response to the COVID-19 pandemic. In particular, we are grateful for your decisions to expand treatment location options to allow hospitals and their communities to better address the surge of patients; open up telehealth options for providers and their patients; and reinforce and support the health care workforce by adding flexibility to important licensing and privileging requirements.

While these actions are providing hospitals and health systems with more flexibility, additional steps are necessary to help providers quickly expand capacity to care for more patients in need of acute care. As you know, COVID-19 has placed unprecedented and rapidly evolving demands on hospitals and health systems, from needing to obtain the necessary certifications to re-open facilities for patient care to requesting the flexibility to transfer certain mechanically ventilated patients to free up capacity when possible. Each of these new challenges requires that providers have every tool at their disposal to combat this emergency and care for patients, which is why we are asking you to consider taking further action, including:



1. Take additional steps to fully implement waivers of the Emergency Medical Treatment and Labor Act, specifically for transfers of patients necessitated by COVID-19.
2. Delay audits related to the Medicare cost report, such as the Medicare disproportionate share hospital (DSH)/S-10 audit, and other federal reviews or audits until after the national emergency to reduce administrative burden and allow providers to focus on patient care.
3. Waive certain telehealth provisions to extend flexibility to hospital outpatient departments (HOPDs) and critical access hospitals (CAHs) by allowing HOPDs to provide care via telehealth and bill for outpatient therapy and psychiatry programs, and permitting CAHs to directly bill for telehealth services and be paid under the payment methodology they have already selected.
4. Ensure that teaching hospitals that increase their bed capacity to address the COVID-19 crisis are not penalized in their indirect medical education (IME) payments. Bed counts used to calculate the resident-to-bed ratio should not include those beds added to increase capacity for patient care during a public health emergency.
5. The Office of Civil Rights (OCR) should confirm that the Health Insurance Portability and Accountability Act (HIPAA) protection extends through the duration of the declared public health emergency. In the alternative, the agency should confirm and announce that it will exercise enforcement discretion and not take action against hospitals that fail to meet the requirements of HIPAA during the COVID-19 crisis.

A list of our specific suggested actions is attached.

In addition to actions already taken using the waiver authority in section 1135, we encourage the agency to continue to address actions private health plans, including those serving Medicare Advantage, Medicare managed care, and Health Insurance Marketplaces enrollees, must take to reduce access barriers and ensure the health care system has the resources to continuing functioning. Specifically, we ask that you work with health plans to ensure that they, like the fee-for-service Medicare program, are supporting network providers with stable cash flow by allowing for accelerated payments for the duration of the public health emergency. In addition, we urge more action by health plans to eliminate administrative processes that cause delays in both access to care and payment, as well as to ensure adequate coverage and reimbursement of services in alternative sites of care. Coordination and assistance from private health plans is necessary to address this pandemic effectively.

Communities rely on America's hospitals and health systems to be there for them in the face of an emergency. Whether that emergency develops in the form of a natural disaster, like a hurricane or tornado, or as a virus, like COVID-19, hospitals and health systems are prepared to fulfill their commitment to patients. While our members continue to do everything they can to address COVID-19 cases, the additional actions

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we are requesting will help them continue to put the health and safety of patients first by removing barriers that threaten to impede decisive and quick action by providers at a time when agility and flexibility are of utmost importance.

We appreciate your leadership and the ongoing work of the White House Coronavirus Task Force. As more information becomes available, we anticipate the need for additional assistance from HHS, and ask that the agency remain flexible as our hospitals and health systems continue to care for patients during this national emergency. We look forward to continuing to work with you during this critical time to protect the health of our nation.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Cc: Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Stephen M. Hahn, M.D., Commissioner, Food and Drug Administration
Robert R. Redfield, M.D., Director, Centers for Disease Control and Prevention

WAIVERS CURRENTLY IN PLACE REQUIRING ADDITIONAL ACTION

EMTALA. EMTALA sanctions are waived for the direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan. In addition to the waiver concerning screening, waivers of sanctions for the following provisions are requested to assist hospitals in most effectively managing patient care and health care system capacity:

- The transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency for the COVID-19 pandemic.
- Permit the medical screening examination to be conducted by other qualified staff authorized by the hospital and acting within their state scope of practice and licensure, who are not formally designated to perform medical screening examinations in the hospital by-laws or in the rules and regulations. This waiver is not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay.

Medical Review Audits. Pausing all audits during the emergency, including additional documentation requests and other audit work, would help free capacity in the health care system. While this list is not exhaustive, pauses on the following audit requirements are requested:

- Medicare DSH/S-10
- Medicaid Payment Error Rate Measurement
- Medicaid DSH
- Quality Improvement Organization (QIO) reviews
- Medicare Advantage plan audits
- Occupational Mix Survey
- Wage Index

Home Health (HH) Face-to-Face Requirement. We request an official statement from CMS confirming that the HH face-to-face encounter can be performed through telephonic or telehealth communications. Allowing this critical function to be accomplished through these means would materially advance both COVID-19 infection control and resource conservation efforts.

Increased VPN utilization for pathologists. Pathologists and other health care professionals can utilize review and sign out for pathology interpretation/diagnosis and other data reviews utilizing virtual private network (VPN) data access. This would allow laboratories to employ appropriate protocols to reduce the risk of infection among their own teams and to avoid hindering their ability to test and treat patients. If laboratory personnel were to be significantly impaired, it could become difficult for the country to continue to respond to this crisis. Providing this waiver will serve to minimize the disruption to the workforce that is occurring while maintaining the best possible patient care.

Prior Authorization for Post-acute Care (PAC). Requiring plans to accept presumptive authorization for PAC placement would enable hospitals to conduct timely patient transfers to free up inpatient bed capacity.

Emergency Use Authorizations (EUs). Expediting the approval of EUs for hospital laboratory developed tests (LDTs), including the approval of licensed automated testing systems and rapid response testing, would assist hospitals in expeditiously testing and confirming COVID-19 infection in patients and thus responding to the emergency.

Audio-only Communication. Allow providers to deliver Medicare telehealth services via audio-only communication.

Medicaid DSH Cuts. Delay Medicaid DSH cuts through FY 2021.

Make explicit that swing beds are included in 3-day SNF waiver. Ensure that the waiver of the 3-day inpatient stay for Skilled Nursing Facility services also is applied to swing bed services, and make this application explicit in documentation. The waiver should be applied to patients being discharged/transferred from both rural and non-rural hospitals to swing bed care, in order to support maintaining inpatient capacity during the COVID crisis.

ASSISTANCE MANAGING THE SURGE

Hospice and Home Health Services. Allow professionals that provide home health and hospice services (including nurses and therapists) to do so via telehealth and bill for them accordingly; also allow home health agencies and hospice organizations that bill under home health and hospice PPS to bill for telehealth services.

Medicare Outpatient Observation Notice (MOON). In addition to CMS' waiver of the SNF 3-day rule, waiving the MOON written and oral notification requirements is appropriate since undergoing observation care will have no implications for SNF eligibility.

Critical Access Hospital (CAH) 96-hour Condition of Payment. Waiving the requirement that a physician certify a patient can reasonably be expected to be discharged within 96 hours would provide critical flexibility for care in rural areas that may not have other options for inpatient care.

Transfer of Mechanically Ventilated Patients. Suspending the restrictions of Medicare Managed Care organizations surrounding transfer of mechanically ventilated patients to long-term care hospitals (LTCHs) would allow patients to be transferred as soon as they are physiologically stable enough. This would facilitate appropriate transfer of patients that benefit from the specialized care LTCHs provide and also add capacity to the health care system.

Waiving certain CMS certification requirements. If a nonprofit entity that holds multiple certificates to operate hospitals in that jurisdiction from the appropriate state licensing entity, a certificate of participation from CMS, a license from a state licensing authority to operate a new or refurbished hospital and has applied for accreditation to operate a new or refurbished hospital that facility may be deemed certified for billing by CMS and private insurance entities. The nonprofit entity would receive certification for no more than 90 days or until accreditation is received or the national emergency has ended. Entities may renew this temporary certification every 90 days for up to one year.

<p>Medicare IME Payments. Hold harmless hospitals that increase their bed capacity during this crisis. As teaching hospitals increase their bed capacity to fight COVID-19, their resident-to-bed ratio, which determines their indirect medical education (IME) payments through Medicare, will be artificially depressed, and reimbursements will be cut.</p>
<p>Enable Better Use of E-visits. Clarify the meaning of “e-visit” and specifically whether patient-initiated screening questionnaires used to determine which patients need telehealth visits are considered e-visits.</p>
<p>Maintain sole community hospital (SCH) status. Hold SCHs harmless from the bed capacity changes among nearby providers. During the emergency, waive enforcement of the SCH classification criteria at 42 CFR 412.92 due to changes in the hospitals or bed counts in the service area.</p>
<p>Support increased bed capacity in rural areas. Hold hospitals harmless for increasing bed capacity during an emergency. Allow providers to maintain pre-emergency bed counts for applicable payment programs, designations, and other operational flexibilities including but not limited to: Medicare Dependent Hospital status, swing bed operation, and special reimbursement for certain provider-based rural health clinics.</p>
<p>LTCH ICU Requirement. Waiving the requirement that an LTCH patient have a prior hospital stay that includes three days or more in the intensive care unit (ICU) in order to qualify for the full payment rate would ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty.</p>
<p>IRF 3-hour Rule. Waiver of the 3-hour rule, which requires that inpatient rehabilitation facility (IRF) patients receive at least three hours of therapy a day, the “preponderance” of which must be one-on-one, would help ensure that IRFs are able to add capacity to the health care system, without penalty.</p>
<p>LTCH 50% Rule. Waiving both the numerator and denominator of the requirement that LTCHs have no more than 50% of Medicare cases paid at the site-neutral rate would help ensure they are able to add capacity to the health care system by caring for appropriate patients, without penalty</p>

ENSURING STAFF CAN FOCUS ON CARE DELIVERY

<p>Expanded Use of Telehealth. Insurers should support management of scarce resources, such as personal protective equipment, and efforts to reduce community transmission by expanding access to services delivered via telehealth.</p>
<p>Credentialing. Requiring expedited or presumptive credentialing, such as requiring health plans to establish a process to recognize and credential community physicians who offer to work at hospitals and health systems, would help to ease workforce shortages during this time.</p>
<p>Patient Assessments. Granting relief to all providers on the timeframes related to pre- and post-admission patient assessment and evaluation criteria would help ensure patients are treated in a timely manner.</p>

Appropriate Use Criteria (AUC) – CMS should extend the Jan. 1, 2021 deadline for providers to use clinical decision support mechanisms to verify AUC before ordering and performing advanced imaging tests on Medicare patients. Compliance will require significant information technology (IT) systems changes, training and compliance resources at a time when IT budgets and staff are increasingly being re-directed to support expanded use of telehealth and other urgent technology needs for COVID-19 response.

CMS Interoperability Rule – CMS should delay compliance for the new condition of participation (CoP) established under this rule requiring hospitals to send admit, discharge, transfer notifications to community providers by at least an additional 12 months to a total of 18 months after publication of the final rule. Across the board, IT budgets and staff are being fully and urgently redirected to support COVID-19 response, including expansion of telehealth to operationalize the flexibilities provided by CMS’ new waivers and policy changes. Given the severity of penalties for non-compliance with the CoPs, it is critical that hospitals have sufficient time to implement this requirement in order to focus all available resources on addressing patient care needs during the current pandemic.

Acute DRG patient exemption from certain IRF PPS requirements. Waiver to allow these Acute DRG patients to be exempt from the IRF PPS admission and coverage criteria, including, but not limited to the patient assessment instrument (IRF-PAI), “three hour rule,” etc. as these items are designed to inform payment and quality measurement for patients undergoing rehab — not the general acute care patients we seek to temporarily house.

HELP US GET THE TOOLS WE NEED

340B Eligibility. Providing for a limited waiver of the 340B Hospital Medicare DSH eligibility threshold for current 340B hospitals responding to the COVID-19 national health emergency and experiencing a significant change in patient mix would help ensure that hospitals do not lose their 340B status in the future as a result of a time-limited change in patient mix.

340B GPO Prohibition for DSH hospitals: Waive the GPO prohibition for 340B DSH hospitals during COVID-19 emergency. Currently, 340B DSH hospitals cannot purchase covered outpatient drugs through group purchasing organizations. Waiving the GPO prohibition, would allow 340B DSH hospitals to more readily access drugs at a lower price than purchasing drugs at Wholesale Acquisition Costs (WAC).

Emergency Department Access to Oxygen. Allow emergency department providers to order home oxygen and provide increased flexibility and leniency of the requirement that 88% oxygen saturation must be met to qualify.

ENSURE COVERAGE SO ALL PATIENTS CAN SEEK HELP WHEN NECESSARY

Presumptive Authorization. Requiring plans to accept presumptive authorization in instances where health plans, due to business disruption such as reduced workforce capacity, cannot adjudicate requests within a timely manner, would help ensure patients are treated in a timely manner.

Presenting Symptoms as Basis for Coverage. Generally, insurers make coverage decisions in part by assessing whether care was medically necessary, and many insurers adjudicate medical necessity using information that becomes available during the course of treatment or testing. This approach could result in many coverage denials for individuals who were originally suspected to have COVID-19 but who ultimately are found to have the flu. The government should clarify that coverage decisions must be made on the presenting symptoms, not the final diagnosis.

Cost-sharing. Mandating that all forms of cost-sharing (co-pays, co-insurance, deductibles) be waived not only for testing, but also for treatment of COVID-19 would help eliminate cost as a barrier to care. CMS also should require plans to reimburse providers for the full contracted amount.

Out-of-network Care. We urge the government to direct health plans to hold the patient harmless for out-of-network care, such as laboratory services, and negotiate reimbursement with the provider.

Utilization Management Requirements. Requiring health plans to ease utilization management requirements during the emergency period to account for reduced workforce would help ensure there are not bottlenecks and unnecessary delays in care. Specifically, hospitals and health systems are expected to experience staff reductions and diversions and health plans should not be permitted to deny reimbursement for care for which providers were unable to complete prior authorization or other utilization management functions due solely to workforce constraints.

Ensuring Adequate Coverage and Resources. Refraining from implementing policies that would reduce Medicaid coverage and/or resources would help ensure patients get the care they need. Specifically, we ask that the Administration withdraw the proposed Medicaid Fiscal Accountability Rule, which could have a negative impact on coverage and health care system resources just as we seek to manage COVID-19 patients.

Automatic Medicaid Eligibility Renewal. Allowing states six month automatic eligibility renewal would help ensure continuity of coverage.

Increase Access to Hospital-based Presumptive Eligibility (HBPE). The Administration should require states to eliminate enrollment barriers for hospitals to expand participation in HBPE such as relaxing the enrollment process, performance metrics, and documentation during the COVID-19 period to increase access to coverage. CMS should encourage states to process HBPE applications for potential beneficiaries through on-line secured portals.

Children's Health Insurance Program (CHIP) Eligibility Limits. Federal law restricts states from increasing their CHIP eligibility limits. We urge flexibility to states seeking to expand CHIP eligibility within their current CHIP grants to enable access to testing and treatment for uninsured children.

Uncompensated Care Pools. Allow states to reestablish or create time-limited Medicaid-funded uncompensated care pools through Medicaid Section 1115 demonstration waivers to cover the costs of the uninsured.

Special Enrollment Period. Creating a special enrollment period for the federal Health Insurance Marketplaces would increase access to coverage and care.

Direct Provider Reimbursement. Establishing a federal program to directly reimburse providers for costs associated with caring for the uninsured would help ensure hospital have adequate resources for addressing the emergency. While federal law now provides a mechanism for reimbursement for testing and testing-related services, this must be expanded to treatment costs as well.

ENSURE PAYMENT FLOWS APPROPRIATELY

Medicaid DSH Allotment Increase. Establish a temporary Medicaid DSH allotment increase to help cover COVID-19 related testing and treatment, including equipment. The increase would apply to FY 2020 Medicaid DSH allotments by adding 2.5%, similar to ARRA. States, however, would be required to distribute payments funded by the allotment increase to directly to DSH hospitals to compensate for increased uncompensated care and Medicaid shortfall costs. The state would function as administrator of the payment, and could not redirect for other purposes (e.g., could not redirect to Section 1115 waiver programs).

Supplemental Payments. Allow states to create new time-limited supplemental hospital payment mechanisms (fee-for-service and managed care) to address COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents program.

Temporary Waiver of Certain Payment Caps. Allow states to suspend any Upper Payment Limit restrictions or Medicaid DSH hospital-specific caps to address hospital payments for COVID-19 related treatment, services, testing without CMS prior approval if state appropriately documents such payments.

Site-neutral Payment Cuts. Immediately cease paying claims for clinic visits provided at excepted off-campus provider-based departments at the reduced payment rate implemented with the 2020 Medicare final rule governing the hospital outpatient prospective payment system. Instead such clinic visit claims should be paid at the rate that would have been in effect absent the payment reduction. Refraining from reducing resources in this manner would help ensure patients get the care they need.

Waive IMD Exclusion for Acute DRG Patients. Allow Medicaid programs to reimburse for care provided in institutions for mental disease (IMDs) for patients transferred from general acute care facilities in order to make room in the latter facilities for COVID-19 patients.

Require Health Plans to Offer Periodic Interim Payments and/or Accelerated Payments. Hospitals are in dire need of continued cash flow to maintain staffing and general operations. While the fee-for-service program has several payment mechanisms that can help during the crisis (periodic interim payment option, as well as accelerated payments), private payers have not implemented similar provisions. This is particularly challenging for hospitals and health systems with high Medicare Advantage

<p>penetration. Urge all private payers contracted with the government to provide these alternative payment options to providers, with an opportunity for reconciliation at the end of the public health emergency.</p>
<p>Medicaid UPL Prospective Payment. Allow hospitals receiving Medicaid UPL payments to receive a prospective payment similar to a loan. States (and hospitals) would then reconcile with CMS at a later date to see if their prospective UPL payment exceeded the UPL limit. If so, the state would enter into a payback arrangement with CMS at a point in the future after the COVID-19 emergency. States would coordinate reimbursement arrangements with UPL hospitals.</p>
<p>Managed Care COVID-19-related Directed Payment. Require hospital directed payments based on COVID-19 treatment through Medicaid managed care arrangements.</p>
<p>Medicaid Disaster Relief Fund. Provide hospitals disaster relief funds through the form of advanced payment programs for fee-for-service and managed care.</p>
<p>Maintain Access to Critical Therapy Services. Allow HOPDs to provide and bill for outpatient therapy services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, via telehealth using any currently approved platform.</p>
<p>Expand Eligibility to Deliver Telehealth Services to Additional Practitioners. Use authority under the CARES Act to waive the remaining statutory restrictions on practitioners eligible to provide services via telehealth, including licensed respiratory therapists, physical therapists, occupational therapists, and speech language pathologists, and allow these practitioners to provide telehealth services from their homes without updating their Medicare enrollment.</p>
<p>Allow CAHs to Provide Telehealth. Allow CAHs to directly bill for telehealth services and allow them to be paid according to the payment methodology they have already selected.</p>
<p>Improve Access to Prescription Drugs. Increase flexibility as providers are quarantined by allowing any other practitioner within the group of a provider who examined a patient within the past 24 months to prescribe via telehealth (rather than allowing only an individual provider covering for the original provider that examined the patient).</p>
<p>Alternative Approaches to Reliance on FY 2020 Medicare Cost Report. In light of the unprecedented challenges that providers currently face, CMS should consider alternative approaches (e.g., blended data, prior cost report years) to utilizing the FY 2020 Medicare Cost Report for programs that depend on cost report information.</p>
<p>Suspend CAH Final Settlement Payments until 12 months after COVID-19 Emergency has Ended. After each fiscal year, CAHs are required to reconcile the cost of providing Medicare services with the interim payments they receive throughout the year. To prevent additional cash flow concerns, any amounts owed by a CAH from this final settlement process should be delayed until after the public health emergency.</p>
<p>Increase Flexibility for Annual Wellness Visits (AWVs). Provide flexibility regarding collection and documentation of vital signs obtained as part of the “Measure” component of AWVs. CMS could achieve this flexibility in several ways, including by creating methods for providers to report AWVs without these components and/or by allowing patients to self-report vital signs when clinically acceptable. Further, waive the requirement of a face-to-face visit for recording hierarchical condition categories (HCCs),</p>

such that providers can capture diagnoses impacting risk adjustment during telehealth visits, including AWWs, further increasing the number of patients who can stay at home and still receive needed care.