

December 23, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Regulatory Relief to Support Economic Recovery; Request for Information

Dear Administrator Verma:

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) appreciates the opportunity to respond to your request for information (RFI) on regulatory relief to support economic recovery. **Specifically, we urge Centers for Medicare & Medicaid Services (CMS) to take additional action to remove certain regulatory barriers standing in the way of efficiency and innovation, thus allowing hospitals to provide better and more cost-effective care to our patients and communities. In order to achieve these objectives, we ask the agency to temporarily extend certain waivers and make others permanent beyond the duration of the COVID-19 public health emergency.**

Since President Trump's declaration of a National Emergency¹ and Health and Human Services (HHS) Secretary Alex Azar's declaration of a Public Health Emergency², your office responded with quick and immediate action to assist providers working on the front lines. Specifically, in reaction to these two declarations, CMS implemented numerous waivers nationwide, including those that have allowed hospitals and health systems to expand access to COVID-19 testing and telehealth, create additional workforce capacity and establish additional treatment locations. Such actions have been

¹ On March 13, the President issued both an emergency proclamation under the National Emergencies Act and a declaration of emergency under the Stafford Act due to COVID-19.

² The HHS Secretary renewed the COVID-19 Public Health Emergency declaration most recently on Oct. 23.



essential in allowing hospitals and health systems to react and adapt swiftly to new patient-care needs, demands and decisions.

America's hospitals and health systems continue to need additional help. While we are encouraged by the recent good news around several vaccine candidates, we cannot lose sight of the difficulties that lie in the weeks and months ahead prior to successful widespread distribution and administration of viable vaccines. As COVID-19 cases surge across the country, coupled with the impacts of colder weather, our members anticipate continued spikes in cases, further challenging an already overworked and overstrained national health care infrastructure. As our members prepare for the coming months, while also looking to the future of health care delivery, both temporary and permanent flexibilities provided by CMS will be critical – including flexibilities for states in managing eligibility, enrollment and delivery changes for their Medicaid programs.

The COVID-19 pandemic has undoubtedly challenged health care delivery and capacity across our country, particularly for our hospitals and health systems. America's health care providers were required to change and evolve the delivery of health care with limited time and no room for error. This environment, while difficult to navigate and extremely unpredictable at times, has shed light on opportunities to better serve patients and communities now and in the future. **Specifically, as part of this experience, our members found that some of their new flexibilities and innovations provided for a better patient experience and high-quality outcomes , regardless of whether they are operating in a public health emergency environment.** These include many waivers related to telehealth that have allowed hospitals to provide much more patient-centered, convenient health care delivery to their communities.

In addition, there are other flexibilities and waivers that may need to continue for a transition period beyond the end of the public health emergency (until a vaccine is successfully deployed widely), but not permanently. These include waivers to policies that are necessary to ensure high-quality patient care, but for which reestablishing "normal" operations will take time. For example, during a transition it may be appropriate to suspend, and even reassess, some of CMS' quality measures or to rethink some of the Conditions of Participation (CoPs) around infection control to ensure hospitals' and other care providers' actions are guided by the best available scientific evidence. It also is necessary to delay or rethink the scope of compliance surveys across the country to ensure hospitals and other organizations have a chance to undo structures and practices implemented for the benefit of patients during the outbreak. In addition, we should continue to remove administrative barriers to ensure patients are receiving the right level of care immediately, especially as backlogged care begins to return to the health care system. For example, one priority would be to require health plans serving public programs to suspend prior authorization for critical services, including post-acute care, so that patients referred to the next care setting but facing a delayed discharge due to stalled prior authorization do not strain hospital capacity.

Therefore, as we continue to respond to the pandemic, while also planning for the next phases of recovery and rebuilding, we ask that you consider retaining a number of regulatory flexibilities beyond expiration of the public health emergency. Our detailed recommendations are below. In addition to these, we also encourage you to work with states to extend or make permanent certain waivers granted in the Medicaid program. For example, consistent with our comments above regarding removing administrative barriers to care, we encourage you to permit states to continue providing flexibility in the application of certain prior authorization requirements as the health care system adjusts post-public health emergency. As demonstrated through the unprecedented work of hospitals and health systems, the flexibilities CMS provided have offered significant opportunity to directly improve the patient experience, increase efficiency, and help advance and expand access to high-quality health care.

Telehealth: On a permanent basis, we urge CMS to continue expanding the services that can be provided via telehealth and via audio-only connection; the locations where these services can be delivered, including in all areas of the country and to patients in their homes; and the practitioners and providers, such as hospital outpatient departments, that can bill for these services. We appreciate the agency's recent efforts to expand telehealth access through the provisions of the physician fee schedule final rule, and encourage CMS to continue working with hospitals and health systems to pursue permanent flexibility where appropriate. These expanded telehealth services support the ability of hospitals and health systems to care for patients, for example, that lack access to transportation and/or for whom visiting the hospital could put them at risk. Specifically, we urge the agency to:

Increase Access and Capacity

- Continue to work with Congress to:
 - Permanently eliminate the telehealth originating and geographic site restrictions to allow for the continued use and payment for telehealth services delivered in a patient's home in any area of the country.
 - Permanently expand eligibility to deliver telehealth services to certain practitioners, such as respiratory therapists, physical therapists, occupational therapists and speech language pathologists.
 - Permanently allow professionals that provide hospice and home health services to do so via telehealth.
 - Permanently allow rural health clinics and federally qualified health centers to continue to serve as distant sites.
- Continue to waive temporarily the restrictions on the type of technology that may be used to provide telehealth by allowing the use of everyday communications technologies, such as FaceTime or Skype.

Provide Payment Flexibility

- Work with Congress to:

- Permanently allow hospital outpatient departments (HOPDs) and critical access hospitals (CAHs) to bill for telehealth services; or, alternatively, clarify the HHS Secretary's authority to enable hospitals to bill for outpatient psychiatry programs and other outpatient therapy services delivered through remote connection in order to provide increased access to those individuals in need of these services.
- Permanently allow hospitals to bill the originating site fee when hospital-based clinicians provide telehealth services to patients at home who would normally receive services at an HOPD.
- Permanently allow providers to bill for a new patient visit provided via telehealth without a physical exam.
- Permanently ensure remote patient monitoring is treated similar to other existing telehealth flexibilities in terms of coverage.

Implement Administrative Flexibilities

- Work with Congress to:
 - Permanently allow providers to deliver Medicare telehealth services via audio-only communications when medically appropriate.
 - Permanently allow hospice and home health face-to-face requirements to be met via telephonic telehealth and permanently allow the professionals providing those services to designate them as Medicare visits.
- Permanently waive certain verbal order requirements to allow for more frequent use of telehealth while protecting patient safety.
- Permanently clarify that providers providing telehealth services at home do not have to update Medicare enrollment addresses.
- Permanently allow virtual check-ins and e-visits for new patients.
- Permanently eliminate the currently required separate consent process for telehealth services and use the telehealth encounter as presumed consent.
- Permanently grant an exception for practitioners in states that have granted reciprocity with regard to medical licensing requirements to file separate Drug Enforcement Agency registration in any state a provider practices to ensure appropriate prescribing for patients through telehealth services.

Workforce: We urge CMS to allow health care professionals to practice at the top of their licenses and permanently permit out-of-state providers to perform certain services when they are licensed in another state. We also recommend that the agency allow extensions to the five-year cap-building period for new Graduate Medical Education (GME) programs to account for COVID-19-related challenges and to support long-term sustainability of physician training. The flexibility this would create in addressing workforce shortages is extremely valuable. Specifically, we urge the agency to:

- Permanently eliminate specific practice limitations on nurse practitioners that are more restrictive under CMS rules than under state licensure to allow professionals to practice at the top of their licenses.
- Permanently remove certain licensure requirements to allow out-of-state providers to perform telehealth services.
- Allow extensions to residency cap-building periods for new GME programs to account for COVID-19-related challenges such as recruitment, resource availability and program operations.

Quality and Patient Safety: We urge CMS to make permanent appropriate changes to the CoPs, such as reconsidering use of verbal orders and certain requirements associated with discharge planning to better equip providers to assist patients.

Doing so would remove unnecessary administrative burden and further CMS' "Patients Over Paperwork" goals. We also recommend continuing several flexibilities past the formal public health emergency declaration, such as those related to personal protective equipment (PPE) use, verbal orders and patient assessments. Specifically, the agency should:

- Permanently scale back current regulations and reconsider the importance of the specific information that is most useful to patients when being discharged to post-acute care facilities, including nursing homes.
- Continue to temporarily modify verbal order requirements to allow verbal orders to be used more frequently and authentication to occur later than 48 hours.
- Continue to grant relief on timeframes related to pre- and post-admission patient assessment and evaluation criteria to ensure patients are treated in a timely manner by allowing hospitals to better manage an influx of non-COVID-19 patients returning for care.
- Continue to allow facemasks to be removed and retained in compounding areas so they can be re-donned and reused during the same work shift as long as a scarcity of PPE remains.
- Continue to allow pathologists and other laboratory personnel to perform certain diagnoses and review remotely through a secure network to ensure continued patient access to the best possible care.
- Continue to maintain flexibility in supervision requirements of diagnostic services by continuing to allow the virtual presence of a physician through audio or video real time communications technology when the use of the technology is indicated to reduce exposure risk for the beneficiary or provider.

Care Delivery in Rural Areas: We urge CMS to continue to support increased bed capacity in rural areas, specifically for critical access hospitals, when an emergency requires such action, as well as hold hospitals harmless for increasing bed capacity during an emergency in the future. These hospitals should

be allowed to maintain pre-emergency bed counts for applicable payment programs, designations and other operational flexibilities. Specifically, the agency should:

- Permanently increase flexibility for site-neutral payment exceptions for providers seeking to relocate hospital outpatient departments and other off-campus provider-based departments in order to better and more effectively serve their communities.
- Continue to support increased bed capacity in rural areas when an emergency requires such action, holding hospitals harmless for increasing bed capacity during an emergency in the future while allowing those providers to maintain pre-emergency bed counts for applicable payment programs, designations and other operational flexibilities.

Administrative Requirements: We urge CMS to provide continued assistance to providers by allowing flexibility of certain administrative requirements, like optional quality measurement reporting during the pandemic and delaying certain reporting requirements to ensure clinical resources are focused solely on patient care. Specifically, the agency should:

- Temporarily permit providers to treat relief funds and other emergency funding mechanisms as grants for cost-reporting purposes to avoid unintended financial offsets.
- Suspend CAH final settlement payments until 12 months after the public health emergency has ended to mitigate unintended cash flow implications and concerns.
- Continue to waive temporarily sanctions and penalties against hospitals that do not comply with elements of the HIPAA privacy rule.
- Continue to provide flexibility for certain administrative and audit compliance requirements, including the occupational mix survey and cost report submissions, which may divert critical clinical resources away from caring for COVID-19 and non-COVID-19 patients throughout the transition period.
- Continue to provide temporarily flexibility for quality measurement reporting requirements through the extension of optional reporting until the end of the year, and coordinate with stakeholders to establish a program to account for unavoidable data gaps in order to hold hospitals harmless.
- Require health plans serving public programs suspend prior authorization for post-acute care services to ensure patients do not experience delays in accessing critical care while also freeing up critical hospital capacity.
- Delay and reconsider the implementation of the new CoP requirement regarding Admission Discharge Transfer sharing established under CMS' interoperability rule, as hospitals have redirected resources necessary to comply with this rule to their COVID-19 responses.

Finally, not all flexibilities and waived provisions can or should remain in place.

For example, waivers such as those relaxing physical environment requirements should cease to remain in place beyond the public health emergency. Waivers treating ambulatory surgery centers (ASC) and certain freestanding emergency departments as if they were hospitals to expand the surge capacity also should expire at the end of the public health emergency. These are effective triage mechanisms, but are not appropriate or applicable to longer-term patient care. Specifically, we urge CMS to:

- Discontinue the flexibility for physician-owned hospitals (POHs) to increase beds, operating rooms and procedure rooms in response to a patient surge and require POHs to return to their pre-COVID-19 bed and room counts, as data indicates these hospitals cherry-pick the healthiest and wealthiest patients, resulting in overutilization and high health care costs.
- Terminate the ability for independent freestanding emergency departments to participate in the Medicare and Medicaid programs as hospitals or clinics. These facilities are not built, equipped or staffed to meet necessary requirements established for Medicare- or Medicaid-participating hospitals and health systems.
- End physical environment flexibilities that allowed for non-hospital buildings and spaces to be used for patient care once the increased capacity is no longer necessary.
- Terminate flexibilities extended to ASCs during the pandemic that have allowed those entities to operate beyond the scope of what they traditionally have been permitted to do. For example, the agency should eliminate the ability for ASCs to keep patients for one or two overnight stays.

Communities rely on America's hospitals and health systems to be there for them in the face of an emergency or disaster, but our work does not end when the public health emergency ends. Rather, it remains the mission and highest priority of our members to provide high-quality health care to each and every community they serve, no matter the circumstances. While our members continue to do everything they can to manage increasing COVID-19 cases, they also must continue to assess and implement programs focused on how to best care for all patients moving forward. The actions we are requesting will help hospitals and health systems continue to put the health and safety of patients first by removing barriers that impact efficiency and opening up opportunities to better put the health, well-being and wishes of patients first in the future.

The AHA appreciates the support and assistance that CMS is providing to our members so that they are best positioned to care for their patients and communities. We ask that the agency remain flexible as our hospitals and health systems continue to care for patients during and after this national emergency. We look forward to continuing to work with you to protect the health of our nation.

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Sincerely,

/s/

Ashley B. Thompson
Senior Vice President, Public Policy Analysis and Development