

**Statement
of the
American Hospital Association
for the
Committee on Finance
of the
United States Senate**

**“COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons
Learned”**

May 19, 2021

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 submit this statement for the record. Since the first COVID-19 cases were diagnosed and the pandemic changed the ways in which patients were able to access traditional health care settings, providers were required to navigate significant challenges to ensure their services were still able to reach millions of patients. In response, Congress and the Administration granted various flexibilities intended to improve access and facilitate the delivery of safe, quality care.

As health care providers reflect on lessons learned and plan a post-pandemic course for the future, it is evident that several of the flexibilities have enhanced the patient experience and led to better outcomes. The AHA believes that, if extended, these flexibilities can continue to drive significant improvements in patient care long after the public health emergency (PHE) ends. Given the beneficial impact of those specific flexibilities, the AHA urges Congress and the Administration to make them permanent. In addition, a second group of flexibilities will remain critically important for some time following the PHE and will require a carefully crafted phase-out plan to ensure enough



time is provided for a necessary transition. Without action from Congress and the Administration prior to the termination of the PHE, we are concerned that much of the progress made because of the implementation of many of these flexibilities may be unnecessarily halted or even lost. America's hospitals, health systems and post-acute care providers have taken significant steps to improve the way care can be delivered due to the pandemic, and failing to seize the opportunity presented by the progress made would be a step back for the nation's health care infrastructure. Following are the AHA's recommendations for each category of flexibilities.

FLEXIBILITIES THAT SHOULD BE MADE PERMANENT

Telehealth Provisions. The increased use of telehealth since the start of the PHE is producing high-quality outcomes for patients, enhancing patient experience, and protecting access for individuals susceptible to infection. With the appropriate statutory and regulatory framework, this beneficial shift in care delivery could continue to improve patient experiences and outcomes and deliver health system efficiencies beyond the pandemic. The AHA urges Congress and the Administration to consider making these flexibilities permanent.

Telehealth policies should work together to maintain access for patients by connecting them to vital health care services and their personal providers through videoconferencing, remote monitoring, electronic consults and wireless communications. We support the following: elimination of the 1834(m) geographic and originating site restriction; coverage and reimbursement for audio-only services; an expanded list of providers and facilities eligible to deliver and bill for telehealth services, including rural health clinics and federally qualified health centers; a national approach to licensure so that providers can safely provide virtual care across state lines; and, adequate reimbursement for the substantial costs of establishing and maintaining a telehealth infrastructure, among others.

Payment Flexibility. In addition to the payment flexibilities needed to continue effectively offering telehealth services beyond the PHE, further payment flexibility is necessary to ensure access to care for patients. Specifically, Congress and the Administration should consider permanently increasing flexibility for site-neutral payment exceptions for providers seeking to relocate hospital outpatient departments and other off-campus provider-based departments. These steps would permit hospitals and health systems to better and more effectively serve their communities.

Hospital-at-Home Programs. The pandemic forced providers to rethink ways to deliver care safely to all patients, while simultaneously responding to surges in COVID-19 cases. To help providers make necessary adaptations, the Centers for Medicare & Medicaid Services (CMS) created new opportunities for providers to implement hospital-at-home programs.

These flexibilities permit approved providers to offer safe hospital care to eligible patients in their homes, and the results have proved pivotal in caring for COVID-19 and

non-COVID-19 patients during the pandemic. While the initial aim of this flexibility was to increase health care capacity while keeping patients safe at home during the PHE, promising outcomes are demonstrating the need for hospital-at-home to be made permanent.

Hospitals and health systems are increasingly interested in standing up hospital-at-home programs, yet many hesitate to do so without assurances that their programs, which are very popular among patients and their families, could continue to exist beyond the PHE. Extending the hospital-at-home flexibilities permanently can engage providers who may be hesitant to implement these programs now and will help transform the way more providers deliver care, while enhancing the patient experience. Given the benefits provided by this program, AHA anticipates considerable additional provider interest and growth of hospital-at-home programs should the flexibilities be made permanent.

Workforce Assistance. The COVID-19 pandemic has exacerbated the strain on an already overworked and understaffed health care workforce. To help mitigate that strain, we support allowing health care professionals to practice at the top of their licenses and permanently permitting out-of-state providers to perform certain services when they are licensed in another state. We also support extensions of the five-year cap-building period for new Graduate Medical Education (GME) programs to account for COVID-19-related challenges and support long-term sustainability of physician training. Permanently extending these workforce flexibilities would help alleviate workforce shortages as the PHE ends.

Review of Certain Conditions of Participation. The PHE has shed light on several shortcomings and outdated practices across the national health care infrastructure; however, it also creates the unique opportunity to reevaluate and improve upon processes based on the lessons we have learned thus far. Conditions of participation (CoPs) are a logical starting point for review and reevaluation, as they serve as the foundation for ensuring high quality care and safety for patients and set the baseline for hospital participation in the Medicare and Medicaid programs. Compliance with the CoPs and the potential for termination from the Medicare and Medicaid programs for non-compliance serve as valuable tools ensuring hospitals are meeting critical safety and quality requirements. However, the past year's experiences demonstrated the need to modernize certain CoPs. For example, reexamining and updating infection control and life safety code requirements would allow hospitals and health systems to continue to employ innovative approaches, such as allowing for separate facility entrances for potentially infectious patients and minimizing personal protective equipment (PPE) use and infection risk by placing IV tubes outside patient rooms. The AHA has urged CMS to collaborate with providers to determine how specific CoPs can be revamped to improve quality and safety.

Rural Capacity. CMS should continue to support increased bed capacity in rural areas when an emergency requires such action. Rural hospitals should be held harmless for increasing bed capacity during any future emergency, and those providers should be

permitted to maintain pre-emergency bed counts for applicable payment programs, designations and other operational flexibilities.

FLEXIBILITIES REQUIRING A TRANSITION PERIOD

Emergency Use Authorization (EUA) Transition. The COVID-19 pandemic placed significant strain on an already fragile medical supply chain and highlighted several substantial flaws in the acquisition process. Many of those impacts still exist today to varying degrees. In response to supply chain disruptions, the Food and Drug Administration (FDA) issued an unprecedented number of EUAs to help mitigate constant disruption and continuous impact. The EUAs covered a broad range of devices, from respirators and COVID-19 tests to ventilators and decontamination systems. These EUAs saved lives by opening up new supply lines to ensure providers have the items they need to safely and effectively care for patients throughout the pandemic. However, the EUAs are not a silver bullet, and additional disruptions will occur post-pandemic. Congress should reassess how the supply chain operates and consider modifications to mitigate further disruptions. To ensure supply chain stability, the FDA should offer full approval to those devices deemed necessary, and provide sufficient transition periods to move away from devices that do not receive full approval.

Personal Protective Equipment. The COVID-19 pandemic illuminated several supply chain shortcomings, not least of which was adequate access to PPE necessary to keep both front-line health care workers and patients safe. In response to the massive PPE shortages, the FDA issued EUAs for a number of items, such as respirators and facemasks. To address the short-and-long-term challenges associated with PPE, the FDA should take steps to ensure a reasonable wind-down of PPE EUA flexibilities to allow the supply chain to recalibrate and providers to use supply on-hand. In addition, the FDA should examine the long-term fragility of the PPE supply chain and consider offering certain non-traditional medical PPE manufacturers the opportunity to receive full medical supply authorization from the FDA. Finally, as this wind-down occurs, the FDA and other federal agencies, including the Occupational Safety and Health Administration (OSHA), the National Institute for Occupational Safety and Health (NIOSH) and the Centers for Disease Control and Prevention (CDC) should work together to ensure a coordinated approach to the transition.

Health Information and Data Sharing. Robust health information and data exchange capabilities among providers and with patients and government agencies are foundational to improving care delivery, supporting better health outcomes and facilitating emergency response. Data exchange capabilities support decision-making at the point of care and the data generated can provide insights into health disparities and inequities at the patient and population health levels. Yet, to realize these benefits, robust, secure infrastructure must be in place for all entities, utilizing a common set of data definitions and standards. Requirements around data collection and sharing also must be well defined and well understood by health care providers and have a clear value proposition. Building this information technology infrastructure requires significant resources, both capital and workforce, and extensive efforts to redesign procedures and

workflows and train clinicians and staff across the organization. Until all of these core building blocks are in place across the health information exchange continuum, implementation of new requirements on health care providers, such as the Office of National Coordination for Health Information Technology's information blocking rules and CMS' admit, discharge and transfer notification CoP, should be delayed.

Quality Measurement Reporting. During the pandemic, CMS provided hospitals relief from quality reporting requirements, including making quality reporting optional in Q1 and Q2 of 2020, and allowing hospitals to apply for reporting waivers using the pandemic as justification. We note, however, that hospital performance on the measurement programs, like readmissions, hospital-acquired conditions and value-based purchasing, will be affected over multiple fiscal years to come, and it is vital that performance be assessed reliably and fairly. For that reason, CMS should use its statutory flexibilities to not apply payment adjustments in program years where it determines that, as a result of measure reporting exceptions, it has insufficient data to calculate national performance in a reliable manner.

Federal Medical Assistance Percentages (FMAP) Increase. The temporary FMAP increase in the COVID-19 relief laws has provided critical financial support for states to ensure their Medicaid programs can provide coverage for millions of their citizens during the COVID-19 pandemic. The temporary FMAP increase of 6.2 percentage points is set to expire at the end of the quarter in which the PHE ends. To benefit from the temporary FMAP increase, states must meet certain maintenance of effort requirements, including continuous enrollment for those enrolled in the program as of March 18, 2020. State governments, advocates and stakeholders recommend that additional federal funding will be needed for up to a year after the PHE ends. Extending FMAP will provide a smooth process to reevaluate Medicaid COVID-19-related coverage extensions.

Congress addressed a similar situation during the Great Recession of 2008-2009. Then, the FMAP was increased by 6.2 percentage points for 27 months (through the end of 2010) and then extended and tapered down from 6.2 % to 3.2% and finally to 1.2% for another six months ending in June 2011. Congress should consider a comparable approach for states at the end of the PHE. Congress also should consider an enhanced FMAP for states with high unemployment rates. During the Great Recession, states with increases in unemployment rates of 3.5% received an enhanced FMAP above the 6.2%.

Medicaid Coverage, Enrollment and Outreach. The PHE enabled states to leverage Medicaid's emergency authorities to make temporary changes to their programs that increased access to coverage and care. Most policies adopted by states helped individuals qualify for and enroll in Medicaid coverage. The two major pathways for states to change Medicaid eligibility, coverage and enrollment during the PHE were: Medicaid disaster relief state plan amendments that allow states to modify their state Medicaid plans quickly to change eligibility, benefits, cost sharing and payments; and disaster relief verification plan addenda that allowed state agencies to verify eligibility and use electronic data sources without prior approval from CMS.

The coverage needs facing states – and the policy changes needed to respond adequately – will continue to exist beyond the PHE. To provide continued flexibility, CMS should relax hospital-based presumptive eligibility standards, maximize flexibility for income verification and the use of self-attestation, and continue allowing qualified entities like hospitals to make presumptive eligibility determinations for all Medicaid eligibility groups.

Post-acute Care. Post-acute care (PAC) providers continue to play a key role in the national COVID-19 response. In communities that faced or are facing surges of the virus, they have treated many of the sickest COVID-19 patients following hospital discharge, as well as provided important relief to hospitals and other settings overwhelmed by patients with and recovering from the virus. Concurrently, the prospective payment systems (PPS) of three of the four PAC settings – the long-term care hospital, inpatient rehabilitation hospital, and skilled nursing facility PPSs – have been in the midst of major payment transformations during the PHE. The collective magnitude of the PHE and these PPS redesigns is extensive, and time is needed for policyholders and stakeholders to disentangle and understand the longer-term ramifications of each. Thus far, their combined impact includes, as examples, material reductions in case volume and overall payments, the rise of average levels of patient acuity, facility closures, personnel shifts and revised clinical pathways. For example, AHA analysis shows that, in comparison to prior patterns, case volume for these settings dropped by 6% to 30% while the average case-mix index rose from between 2.5% and 6.9% over the prior year.ⁱ In recognition of this complex dynamic, the recent FY 2022 PAC proposed rule calls upon stakeholders to provide guidance on how to account for both of these overlapping and powerful drivers of change. At this time, it remains unclear which of these and other operational impacts will persist after the PHE, but given their scope and duration, it seems possible that the PAC field will not return to its pre-PHE profile. Given this level of change and uncertainty, key PAC flexibilities should remain in effect during a transition period that follows the official end of the PHE. In particular, such extended flexibilities should include PHE-levels of payment and coverage for highest acuity COVID-19 patients who remain in the PAC setting following the PHE, including those “long-haul COVID-19 patients” for whom the virus has concluded but related symptoms remain.

The AHA is gratified that the Committee is examining the many flexibilities granted during the COVID-19 pandemic. We stand ready to work with the Committee as you consider learnings from these flexibilities and how to ensure that the nation’s health care system can continue to evolve for the benefit of patients and the health of their communities.

ⁱ These data compare a 12-month period during the PHE, January 27, 2020 through January 26, 2021, to a pre-PHE 12-month period, January 26, 2019 through January 26, 2020. Data source: Medicare fee-for-service claims, Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse, <https://www2.ccwdata.org/web/guest/home>.