American Hospital Association™
Advancing Health in America

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February 7, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Creating a Glide Path from Public Health Emergency to a More Effective, Equitable, Patient-focused and Stable Health Care System

Dear Secretary Becerra:

Our nation has been tested by the COVID-19 pandemic more than it has with any other crisis in the past 75 years. The health care system, with America's approximately 6,000 hospitals and health systems at the center, met the challenges posed by the disease and saved countless lives with skill, compassion, and often great personal sacrifice on the part of the health care workforce. **The recent decision to sunset the COVID-19 public health emergency (PHE) is a testament to the progress we have made; however, as we prepare for that transition, we should not revert to care delivery as it was prior to the pandemic. Instead let us build on the lessons we have learned and the advancements in care delivery and access we have made. Let us use this crisis to create a more effective, equitable, patient-focused and stable health care system.**

Achieving these goals requires immediate action by the Administration as the conclusion of the PHE will end several PHE-specific programs and policies that are critical to the evolution of the health care system. Specifically, we urge you to take actions to help **stabilize the health care delivery system** to ensure care remains available to patients when and where they need it; **support the health care workforce** as they continue to shoulder a disproportionate amount of strain caused by the PHE; and **remove unnecessary administrative and regulatory burdens** that prevent providers from modernizing care delivery while adding cost and friction in the health care system. These actions include:

- Making permanent many of the policies authorized through waiver authority during the PHE that enabled hospitals and health care systems to deliver care more effectively and efficiently. These policies include expanded use of

telehealth, workforce flexibilities, and the reduction of unnecessary regulatory and data reporting requirements;
- Continuing to assist states and other stakeholders in ensuring that the Medicaid redetermination process does not leave individuals, especially children, without access to coverage and care; and
- Seizing on the lessons learned to create new processes for evaluating and revising certain hospital Conditions of Participation, as well as updating the Department's emergency preparedness plan enabling America's hospitals and health systems to innovate in ways that will improve the quality of and access to care while also adequately preparing them for the next national emergency.

We recognize that while the Administration has significant ability to act, there are some reforms that require congressional authorization, such as the ability to make permanent certain telehealth flexibilities and address the challenge of patient boarding in hospitals. We urge the Administration to work with Congress to advance these reforms.

We expand on each of these recommendations in the attached. We thank the Administration for its continued support and look forward to working with you to implement meaningful and necessary change. Please contact me if you have questions, or feel free to have a member of your team contact Mark Howell, AHA's director of policy, at 202-626-2317 or mhowell@aha.org.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Attachment A: Recommendations for Immediate Administrative Action
Attachment B: Recommendations for Congressional Action
Attachment C: Summary Chart of Recommendations

Attachment A: Recommendations for Immediate Administrative Action

Stabilizing the Health Care Delivery System

Hospitals' and health systems' capacity to care for individuals is strained as they continue to experience an influx of high acuity patients, struggle to discharge existing patients to post-acute sites of care and navigate ongoing labor shortages and supply disruptions. Among other challenges, these factors have led to both rising costs and constricted revenue, which combined have created an unprecedented fiscal crisis. Indeed, approximately half of hospitals and health systems are operating with negative margins. This situation is not sustainable and jeopardizes providers' ability to continue serving their patients. The expiration of a number of waivers that have been critical to enabling hospitals and health systems to provide — and be reimbursed for — care will only further destabilize their operations and finances. **We therefore urge you to take the following steps as the PHE winds down to help ensure that the health care delivery system can be there when patients need it:**

- **Permanently Authorize Expanded Coverage of Telehealth Services.** COVID-19 forced hospitals and health systems to rapidly deploy new and innovative ways of delivering care, like expanded telehealth, to care for patients. This progress was spurred by the immediate need to expand access to services, while simultaneously working to prevent increased transmission of COVID-19 and was supported by a series of waivers approved by the Centers for Medicare & Medicaid Services (CMS). While the impetus for these programs was COVID-19, their value beyond the pandemic could not be more evident. Therefore, we encourage the Administration to permanently extend coverage of certain telehealth services, including:
    - The ability to use telehealth services to meet the face-to-face recertification requirement for hospice care;
    - Telehealth reimbursement parity based on the place of service where the visit would have been performed in person;
    - Incident to billing and direct supervision via telehealth;
    - Removal of the in-person visit requirement for the prescribing of controlled substances through rulemaking by the Drug Enforcement Agency (DEA); and
    - Coverage and payment for audio-only telehealth services.

- **Bolster Rural Capacity.** Rural hospitals play a unique role in preserving patient access to care. Many of the flexibilities provided during the pandemic enabled rural hospitals to keep their doors open and caring for patients — and those flexibilities, if continued, would continue to support these uniquely challenged providers. To support rural capacity, we urge you to adopt a permanent policy of flexibility in bed capacity in rural areas when an emergency requires such action, by proactively holding hospitals harmless for increased bed capacity and

allowing providers to maintain pre-emergency counts for applicable payment programs, designations and other operations.

- **Recognize and Support Distinct Sites of Post-acute Care.** The pandemic has provided valuable insight into the unique role and capabilities of the distinct sites of institutional post-acute care. However, rising costs and workforce shortages, as well as lagging reimbursement has made it difficult for these providers to meet patient care demands. Therefore, HHS should ensure that post-acute care coverage and reimbursement policies, including any effort to reform post-acute care payments, reflect these insights, and preserve robust patient access to long-term care hospitals, rehabilitation hospitals, skilled nursing facilities and home health agencies.

- **Mitigate Coverage Loss.** Comprehensive health care coverage is critical to patient access to care and adequate resourcing of the health care system. Several policies related to the PHE resulted in the lowest rate of uninsured in U.S. history, including expansions of coverage under both Medicaid and the Health Insurance Marketplaces. As we look toward the end of the COVID-19 PHE, certain vulnerable populations are at risk of losing coverage, particularly through the Medicaid redetermination process. While CMS has gone to great lengths to provide resources and assistance to states to ease the process and Congress has provided greater clarity in the timeline and rules, there remain concerns that some individuals could lose coverage during this time. A substantial loss of coverage would both put patient access to care at risk, while also threating the financial viability of the providers who care for them. **We urge the Administration to continue efforts to ensure that the rollback of certain coverage gains made during the PHE do not detrimentally impact those individuals who rely on these programs, including through finalizing policies that ease the transition between Medicaid and the Marketplaces, public messaging campaigns, stakeholder engagement and support to states.**

- **Monitor for Continued Access to Vital COVID-19 Care.** At the expiration of the PHE, coverage of certain COVID-19 care provided at no cost-sharing will expire. In addition, the federal government will no longer procure and provide free of charge vaccines and certain drugs. While we are optimistic that payers will recognize the inherent value of these services and establish appropriate coverage policies, **we urge the Administration to monitor patient access to such services and move swiftly, if necessary, to ensure that payers are adequately covering all medically necessary care.**

- **Extend New COVID-19 Treatments Add-On Payment (NCTAP) and Incorporate the Cost of Care for Treating COVID-19 Patients.** NCTAPs are enhanced payments for eligible inpatient cases that use certain new products to treat COVID-19. Currently, these additional payments will expire in the fiscal

year in which the PHE ends. Hospitals and providers need continued support to help care for patients with COVID-19, and these products remain lifesaving treatments for hospitalized patients. These products include convalescent plasma, remdesivir and PAXLOVID, among others. **We urge the Administration to extend these payments beyond the fiscal year and to carefully evaluate the high cost of care associated with treating COVID-19 patients.**

- **Provide Waiver-related Resource to Assist Providers with Anticipated Audits.** As part of our work preparing for the PHE to sunset, there is some concern that future audits of hospitals and health systems could be mired by confusion or uncertainty around which policies and requirements were waived, when they were waived and for how long. Given this concern, and the potential issues it could raise in the future, we urge the Administration to create and disseminate resources that explain the scope and scale of the waivers and COVID-19-specific policies that were implemented over the course of the pandemic so that hospitals and health systems can use that resource during audits, if necessary.

Supporting the Health Care Workforce

Hospitals and health systems exist and function because of the doctors, nurses, technologists, facilities management specialists and many other professionals who work in them. They cannot take care of patients without these caregivers, and yet, across the country, hospitals continue to report critical shortages of nurses, physicians and other vital health care professionals. Many health care workers are suffering from stress and trauma from the last three years of the pandemic, and we must do more to support the health care workforce. **We urge the Administration to permanently:**

- **Eliminate Specific Nurse Practitioner Practice Limitations that Are More Restrictive under CMS Rules than Under State Licensure**. Nurses play some of the most vital roles in our care delivery system, yet we have failed to fully recognize and implement the skillset and expertise of many nurses. Allowing nurses to practice at the top of their license not only can help to alleviate some current workforce challenges, but it also will serve as a strong tool for recruitment and retention.

- **Expand Role of Pathologists and Other Laboratory Personnel.** Allow pathologists and other laboratory personnel to perform certain diagnostic tests and review the results remotely through a secure network to ensure continued patient access to the best possible care. By allowing these individuals to perform their job remotely, CMS will create the opportunity for a more efficient process that provides the same, high-level quality care.

- **Maintain Flexibility in Supervision Requirements of Diagnostic Services by Allowing the Virtual Presence of a Physician through Audio or Video Real-time Communications Technology.** As hospitals and health systems continue to manage challenging bandwidth issues among their workforce, allowing for the increased utilization of technology affords providers the ability to serve more patients while providing the same high-quality care.

- **Allow Extensions to Residency Cap-building Periods.** America's hospitals and health systems have not only had to go to extraordinary lengths to retain current staff, but they also have had to navigate difficulty in recruitment of new staff. The health care workforce pipeline has been a concern for some time, but the COVID-19 pandemic accelerated the scope and scale of those concerns, leaving many providers in a dire situation when it comes to securing staff for the future. To help alleviate some of the immediate pipeline issues, the Administration should continue to allow extensions to residency cap-building periods for new graduate medical education programs. These extensions will not only account for the many COVID-19-related challenges, but will provide longer-term recruitment opportunities, increase resource availability and support program operations.

Removing Unnecessary Administrative and Regulatory Burden

Every day, hospitals and health systems confront the daunting task of complying with a complex set of federal regulatory requirements, many of which have outlasted their relevance. The associated burden contributes to clinician burnout and drives up the cost of delivering care. At the outset of the COVID-19 pandemic, HHS waived many regulatory requirements for hospitals and health systems to ease burdens on the health care system allowing doctors, nurses and other care givers to focus their time and energy on patient needs. In many cases, those waivers demonstrated changes to the Conditions of Participation (CoP), that should be made permanent. To advance efforts towards appropriate burden reduction and regulatory relief, we encourage the Administration to take the following steps.

- **Revise and Simplify Discharge Planning Requirements.** The pandemic required significant action to simplify regulatory requirements to ensure providers could focus as much time as possible on patient care. The scaling back of discharge planning requirements was one of the most critical reductions in regulatory burden during our response to COVID-19. However, the benefits associated with these scaled back requirements also have demonstrated their need for revision. The current requirements overwhelm both patients and providers by requiring the providers to share information that is overly complicated and often not germane to a patient's specific situation. Rather than reinstitute this practice, we should take advantage of the opportunity to rethink what information is necessary and more useful for patients as part of the discharge planning process. We urge the Administration to continue with the

scaled back version of discharge planning while focusing on releasing updated requirements in the near future. Those revisions should place an emphasis on patients, the information that is most meaningful for them, and providing that information in an easy-to-understand, clear and concise manner as they leave the hospital.

- **Permanently Permit Verbal Orders.** Verbal orders provide a level of timeliness and efficiency not afforded by written orders, while also demonstrating the ability to reduce errors that may not be as easily corrected when using written orders. While preference around the type of order employed and when should remain the decision of the organization and its health care workers, the option to choose one should be available to providers.

- **Continue Flexibility in Patient Assessment Timelines.** Continue to provide flexibility on timeframes related to pre- and post-admission patient assessment and evaluation criteria to ensure patients are treated in a timely manner and allow hospitals to better manage an influx of non-COVID-19 patients returning for care. While this current waiver does not need to be made permanent, it provides necessary flexibility for clinicians so that they can focus their time more efficiently and effectively on the current influx of increased patient care needs.

- **Streamline Public Health Data Reporting.** Hospitals and health systems support the collection and reporting of data that meaningfully informs decisions related to the nation's health and well-being. However, the approach to collecting COVID-19 data exposed myriad challenges, including unrealistically burdensome requests during a time when all available personnel were responding to an emerging situation on the ground, as well as excessively punitive consequences for failure to report. Some of these data reporting requirements persist and the end of the PHE marks an appropriate time to rethink our PHE data collection strategy. **To that end, we recommend the following actions to improve the current data collection and reporting requirements to focus on value and quality of the data over quantity:**
    - Let the COVID-19 data reporting CoP expire at the end of the PHE and re-establish HHS' voluntary mechanism to collect COVID-19-related data;
    - Partner with hospitals and health systems to focus and streamline the number of requested data elements and take steps to reduce the frequency of the reporting;
    - Provide a rationale that justifies the value of and projected use for the collection of specific data and seek input from hospitals and health systems on the meaningfulness of that perceived value; and
    - Act, in collaboration with necessary stakeholders, to build out a national data infrastructure capable of sharing important public health information between providers and federal and state agencies.

Ensuring Proper Regulatory Requirements and Emergency Preparedness

There is a clear and necessary opportunity for HHS to place a renewed focus on establishing a regulatory framework that ensures patient safety, while taking steps to reduce unnecessary burden and refocus on the future of health care delivery. The issues we suggest are meant to build on that which we have learned from the COVID-19 pandemic to ensure America's hospitals and health systems can dedicate more time to patient care, while also preparing providers for the challenges that lay ahead.

- **Establish Routine Review and Updating of Regulatory Requirements.** While the pandemic accelerated certain changes within the health care system, the reality is that care delivery is evolving at a rapid pace. One key learning from the pandemic is the need to routinely and systematically review the regulatory framework and eliminate outdated, unnecessary or duplicative requirements. For example, as hospitals and health systems make decisions about the future of their facilities, they often find that local or state code regulations conflict with outdated CMS life safety codes. These conflicts stifle innovation and prevent hospitals from making investments in the most up-to-date construction and building advancements by forcing compliance with federal LSC requirements that have failed to adapt to the changes around them. Further, the Inflation Reduction Act (IRA) presents a great deal of opportunity for hospitals and health systems seeking to invest in cleaner, newer energy technologies, like microgrids; however, outdated LSCs are putting providers in a difficult position where opportunity to invest in cleaner, more reliable energy exists, but it is outweighed by the potential for regulatory noncompliance. **To alleviate these constraints and ensure a coordinated approach moving forward, the Administration should establish a routine rulemaking process to be undertaken every three years with the goal of determining which LSCs should be updated or eliminated to mirror code updates across the country.**

- **Update HHS' Emergency Preparedness Playbook.** COVID-19 demonstrated the need for significant changes to emergency preparedness processes and procedures across the health care sector. Currently, emergency preparedness CoPs exist for hospitals and health systems, but COVID-19 demonstrated that the current emergency preparedness framework for our national health care delivery infrastructure is insufficient for effectively responding to a national public emergency of this scale.

  In general, the national emergency preparedness plan anticipates emergencies of limited size and duration, such as a hurricane, earthquake or mass casualty event in a community. Similarly, many hospital plans and drills were built around responding to such scenarios. While such emergencies are far more common than nationwide emergencies, the challenges of a broader, longer-lasting emergency such as the pandemic necessitate planning for and practicing responses to such events. Most importantly, broad-scale emergencies and long duration emergencies require connections and collaborations that far exceed those used in a more localized, time-limited emergency. That collaboration

creates and fosters the opportunity to use the strengths of health care systems and the experiences of practitioners on the front line of the emergency to inform other clinicians across the country in ways that would not be needed in a more localized emergency. Further, national emergencies have unique challenges, such as discordant decisions about the right approaches to safeguarding citizens, uneven distribution of life-saving resources and expertise, lack of clarity around who oversees what aspect of care and a more significant drain on available resources. CMS' requirements for hospitals and other sites of care need to be rethought and modernized to emphasize the need for better planning, better coordination and better collaboration among care delivery sites.

It also is likely that HHS' own plans for responding to a national emergency need to be rethought and better coordinated with partners not only at the state-level, but also with the organizations that will be key to an effective national response, including hospitals. For example, the Administration for Strategic Preparedness and Response's Strategic National Stockpile was not designed to provide sufficient backup during an event like the COVID-19 PHE; the Center for Disease Control and Prevention's plans for managing the distribution of information and critical supplies, like vaccines and therapeutics, only extended to the point of distributing the vital resources to the state but failed to follow-through to the point of ensuring safe administration to intended recipients; and opportunities for clinicians to get their critical questions answered in the first year of the pandemic were quite limited until CMS stepped up to provide frequent mass calls. **These issues and others require serious thought and attention, and we encourage the Administration to consider and address them in HHS' updated emergency preparedness playbook.**

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Attachment B: Recommendations for Congressional Action

While the Administration has tremendous ability to make advancements in federal policy and programs to effectively transition the health care system out of the PHE, we recognize that there are some areas where Congress must provide new authority. We encourage the Administration to work with Congress in the following ways in pursuit of our vision for a more effective, equitable, patient-centered and stable health care system.

- **Expand Access to Care via Telehealth.** As previously noted, the expanded use of telehealth has been a fundamental catalyst of positive health care system transformation during the PHE, enabling providers to safely expand access to care and provide high-quality care more conveniently for patients. In addition to the recommendations for changes under the Administration's purview, we encourage you to work with Congress on changes in law that would further support hospitals' and health systems' ability to improve access using these technologies.
    - **Enable Coverage of Telehealth Services No Matter the Patient's Location.** Under current Medicare law, under most circumstances, patients cannot receive services via telehealth unless they are physically located in a specific location, e.g., a physician's office and in a rural area. These provisions have always been significant limiting factors for providers' ability to use telehealth to expand access to care. The waiver of geographic and patient site restrictions during the pandemic enabled the health care system to demonstrate the utility, safety and convenience for patients of receiving telehealth services in other sites, including their home, and in both urban and rural locations. We urge Congress to enable the originating site to be any site at which the patient is located, including the patient's home.

    - **Continue the Ability for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to Furnish Telehealth Services.** Historically, restrictions have been made on allowed distant sites (the locations where providers administering telehealth could be located). Since part of the benefit of telehealth is the ability to connect patient demand with provider capacity, restricting the sites for providers to administer services can negatively impact access and, in some cases, reduce patients' abilities to connect with their own providers. We support

allowing RHCs and FQHCs to serve as distant sites, so that these facilities may use the providers at their own sites to offer care to patients, ensuring patients remain connected to their primary providers.

- **Repeal the Six-month In-person Requirement for Mental Health Services Furnished through Telehealth, including the In-person Requirements for FQHCs and RHCs.** The Consolidated Appropriations Act of 2021 requires that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and must have an in-person visit annually thereafter. However, this requirement may, in fact, adversely impact access, quality and cost for behavioral health services. While some patients may benefit from a periodic in-person evaluation, it should be left to clinical judgment rather than an arbitrary general requirement. We recommend repealing the in-person visit requirements for behavioral telehealth services.

- **Expand Practitioners Eligible to Furnish Telehealth Services to include Occupational Therapist, Physical Therapist, Speech-language Pathologist and Audiologist.** Historically, Section 1834 of the Social Security Act limited the types of providers who were able to administer telehealth services; during the pandemic, the list was expanded to include additional provider types like rehabilitation therapists which improved access to services. Given the improved access and high levels of satisfaction we encourage permanent expansion of eligible provider types able to perform telehealth services.

- **Bolster Rural Capacity.** In addition to our previous recommendations, we encourage the Administration to work with Congress to:
  - Permanently remove the 96-hour physician certification requirement for Critical Access Hospitals (CAHs), which would allow CAHs to serve patients needing critical medical services that have standard lengths of stay greater than 96 hours. Enforcement of this requirement has resulted in CAHs either refusing care, forgoing payment or being forced into an unnecessary and expensive transfer of a patient to a larger facility; and
  - Eliminate the 96-hour annual average length of stay (LOS) given ongoing capacity issues at CAHs and the critical role they play in providing care in rural communities. Patients who can be safely and effectively treated and require more than a 96-hour stay in their local hospital should be afforded the option of receiving care closer to their homes, families and usual doctors.

- **Establish a Permanent Hospital-at-Home Program.** Like the expansion of telehealth services, hospital-at-home programs across the country served as a critical mechanism in expanding hospital capacity while limiting risk of exposure to COVID-19. These programs have demonstrated high-levels of patient

satisfaction, strong health care workforce buy-in and engagement and opportunities to provide care that is better informed by the patient's home environment. In addition, hospital-at-home patients frequently experienced decreased recovery times and fewer adverse events related to the care they received. The CoP waivers allowing for hospital-at-home programs to operate was extended for two years in the Consolidated Appropriations Act of 2023, but additional action will be necessary to secure the program's long-term permanency and demonstrate investment and confidence in new care delivery models for the future. **We urge the Administration to work with Congress to develop and establish a permanent hospital-at-home program.**

- **Support Hospitals' Ability to Discharge Patients.** One of the most significant challenges facing hospitals is the inability to move patients ready for discharge to the next appropriate site of care. The average length-of-stay for patients being discharged to post-acute care providers has increased nearly 24% from 2019 to 2022. This remains true even after accounting for patients being sicker and requiring more complex and intensive care now as compared to pre-pandemic levels. Delays in discharge can negatively impact patients' health outcomes or slow their recovery by forcing them to stay in the hospital longer than medically necessary. They also put additional pressure on an already overwhelmed workforce and strain hospital resources as hospitals are not reimbursed for the costs of caring for patients being boarded in hospitals. **As such, we urge the Administration to work with Congress on the following two policies.**

    - **Give CMS Authority to Waive Prior Authorization Requirements during PHEs.** During the PHE, providers' ability to access timely care for their patients was often severely curtailed by health plan utilization management rules, especially prior authorization. This not only delayed critical patient care, but it also hampered hospitals' ability to free up inpatient capacity for the influx of patients who desperately needed care. While the Administration encouraged Medicare Advantage (MA) plans to ease their use of these rules to facilitate access, they lacked the authority to require it. As we look toward the future, we encourage Congress to give CMS the tools it needs to respond effectively and comprehensively. **We therefore urge Congress to provide CMS with the authority to suspend MA plan prior authorization processes during times of declared emergency.**

    - **Ensure Medicare Coverage for Excess Patient Days and Support for Post-acute Care Providers.** Medicare generally pays for an inpatient's hospital stay by one fixed amount based on their diagnosis and severity, regardless of how long they are in the hospital. As a result, hospitals are incurring more costs to care for sicker patients for longer periods of time, while facing reimbursement levels that fall short of these higher costs. **We urge Congress to establish a temporary per diem Medicare payment**

targeted to hospitals to ease capacity issues. Per diem payments should be made for inpatient cases identified and assigned with a specific discharge code that fall under such type of long stays where the patient is documented to be ready for discharge but is unable to be discharged appropriately. **Similarly, we urge Congress and the Administration to ensure they provide additional resources to post-acute care providers to allow them to continue to ensure patient access to high-quality care.**

Attachment C: Summary Chart of Recommendations

Recommendations for Administrative Action		
Goal	**Recommendation**	**Status**
Stabilize the Health Care System	1. Permanently authorize expanded coverage of telehealth services, including:	
	• The ability to use telehealth services to meet the face-to-face recertification requirement for hospice care	Authorized by Congress through 2024. HHS has authority to make permanent.
	• Telehealth reimbursement parity based on the place of service where the visit would have been performed in person	Authorized via rulemaking through 2023. HHS has authority to make permanent.
	• Incident to billing and direct supervision via telehealth	Authorized via rulemaking through 2023. HHS has authority to make permanent.
	• Waiver of the in-person visit requirement for the prescribing of controlled substances in certain instances through rulemaking by the DEA	Authorized via waiver that will expire at end of the PHE. DEA has authority to permanently establish via rulemaking circumstances that would result in waiver.
	• Coverage and payment for audio-only telehealth services	HHS has authority to make permanent.
	2. Bolster rural capacity by allowing increased bed capacity in rural areas when an emergency requires such action.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	3. Recognize and support distinct sites of post-acute care.	New action. HHS has authority to act.
	4. Extend New COVID-19 Treatments Add-On Payment (NCTAP) and incorporate the cost of care for treating COVID-19 patients.	Set to expire in the fiscal year in which the PHE ends. HHS has authority to extend.
	5. Mitigate coverage losses by adopting policies to streamline the transition from Medicaid to the Marketplaces, undertaking consumer education and public messaging, and supporting states.	Administration can act through existing authority.
	6. Monitor for continued access to vital COVID-19 care.	HHS oversight authority generally exists but may

		require Congress to authorize new coverage.
	7. Provide waiver-related resources to assist providers with anticipated audits.	New action. HHS has authority to act.
Support the Health Care Workforce	8. Eliminate nurse practitioner practice limitations that are more restrictive under CMS rules than under state licensure.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	9. Permanently allow pathologists and other laboratory personnel to virtually perform certain diagnostic tests and related services.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	10. Permanently allow provider flexibility in supervision requirements of diagnostic services by allowing the virtual presence of a physician through audio or video real-time communications technology.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
	11. Permanently allow extensions to residency cap-building periods.	Authorized via waiver that will expire at end of the PHE. HHS has authority to make permanent.
Remove Unnecessary Administrative and Regulatory Burden	12. Scale back overly burdensome requirements associated with discharge planning.	Authorized via waiver that will expire at the end of the PHE. HHS has authority to act.
	13. Permanently allow for the use of verbal orders under the CoPs.	Authorized via waiver that will expire at end of the PHE. HHS has authority to act.
	14. Permanently provide flexibility on timeframes related to pre- and post-admission patient assessment and evaluation criteria.	Authorized via waiver that will expire at end of the PHE. HHS has authority to act.
	15. Streamline public health data reporting.	New action. HHS has authority to act.
Ensure Proper Regulatory Requirements and Emergency Preparedness	16. Establish routine review and updating of regulatory requirements.	New action. HHS has authority to act.
	17. Update HHS' emergency playbook.	New action. HHS has authority to act.

Recommendations for Congressional Action	
Recommendation	**Status**
18. Allow the originating site to be any site at which the patient is located, including the patient's home.	Authorized by Congress through 2024. Congress must act to make permanent.
19. Allow FQHCs and RHCs to furnish telehealth services.	Authorized by Congress through 2024. Congress must act to make permanent.
20. Repeal the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs.	Authorized by Congress through 2024. Congress must act to make permanent.
21. Expand practitioners eligible to furnish telehealth services to include occupational therapist, physical therapist, speech-language pathologist and audiologist.	Authorized via waiver that will expire at the end of PHE. Congress must act to make permanent.
22. Establish a permanent hospital-at-home program.	Authorized by Congress through 2024. Congress must act to make permanent.
23. Expedite the safe discharge of patients to appropriate post-acute sites of care by giving CMS authority to waive MA prior authorization and other utilization management rules during PHEs.	New action. Congress must act to make permanent.
24. Compensate hospitals for days spent boarding Medicare patients who are ready for discharge and provide additional support for post-acute care providers.	New action. Congress must act to make permanent.
25. Permanently remove the 96-hour physician certification requirement for CAHs.	Enforcement deprioritized during PHE. Congress must act to make permanent.
26. Eliminate the 96-hour annual average LOS requirement at CAHs.	Authorized via waiver that will expire at the end of the PHE. Congress must act to make permanent.