American Hospital Association™
Advancing Health in America

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July 29, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Dear Administrator Brooks-LaSure:

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) urges you make some COVID-19 waivers permanent, as well as retain other regulatory flexibilities beyond expiration of the public health emergency (PHE), in order to continue advancing the delivery of health care in America.

During the early days of the pandemic, the Centers for Medicare & Medicaid Services (CMS) moved quickly to waive certain regulatory requirements. These waivers were granted so hospitals and health systems could innovate to provide care with a focus on separating patients with, or suspected of having, COVID-19 from those with other health care needs, expanding access to COVID-19 testing and telehealth, creating additional workforce capacity and establishing additional treatment locations, among other benefits. Such actions were essential to hospitals during the pandemic and allowed them to adapt swiftly to new patient-care needs. In the process, we discovered ways to be more patient-centered, to take greater advantage of technology and to reduce the burden on staff and patients. In short, much of this innovation led to improvements in care. **Therefore, we urge CMS to take additional action to permanently remove certain regulatory barriers standing in the way of better patient care.**

Further, we ask the agency to temporarily extend certain waivers beyond the duration of the COVID-19 PHE to enable a thoughtful transition back to normal care delivery. It will take time to reestablish the capability for some types of “normal operations.” For example, as CMS has already indicated in several of its fiscal year proposed rules, it may be appropriate to suspend or reassess the use of some of CMS’ quality measures. Similarly, it may be necessary to delay or rethink the scope of compliance surveys to ensure hospitals and other organizations have a chance to undo structures and practices implemented during the outbreak.

Our detailed recommendations are below.

Detailed Recommendations

Telehealth

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 those individuals especially vulnerable to infection. This shift in care delivery could outlast the PHE if the appropriate statutory and regulatory framework is established.

Moreover, there has been a sharp rise in admissions related to other diseases or disorders that went untreated during the height of the pandemic — in particular, the large number of people suffering from mental health or substance use disorders that were exacerbated by isolation during the pandemic and the increase in violence and trauma being experienced in several locations around the U.S. Hospitals can use their new telehealth capabilities to help these patients and many more if the flexibilities become a permanent feature of how care is delivered.

We urge CMS to continue expanding the itemized list of services that can be provided via telehealth or audio-only connection. Specifically, we urge the agency to waive 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. We also urge CMS to make permanent the expanded list of locations where these services can be delivered, including in all areas of the country and to patients in their homes, and the expanded list of practitioners and providers that can bill for these services.

It is particularly important that hospital-based clinics and ambulatory sites be among the acceptable originating locations to enable frequent interactions with patients with complex chronic conditions. Telehealth services also enhance the ability of hospitals and health systems to care for patients who lack access to transportation and/or for whom visiting the hospital could pose unnecessary risk. We appreciate the agency's efforts to expand telehealth access through the provisions of last year's physician fee schedule final rule, and encourage CMS to continue working with hospitals and health systems to pursue permanent flexibility where appropriate.

Additionally, we urge CMS to make certain provider payment and other administrative flexibilities permanent, including:

- permanently allow providers to bill for a new patient visit provided via telehealth without an in-person physical exam;
- permanently allow verbal orders in telehealth visits;
- permanently allow virtual check-ins and e-visits for new patients;
- ensure remote patient monitoring is treated similarly to other existing telehealth flexibilities in terms of coverage;

- permanently allow all telehealth services, as clinically appropriate, to be delivered via audio-only connection;
- permanently eliminate the currently separate consent process for telehealth services and use the telehealth encounter as presumed consent;
- permanently grant an exception for practitioners in states that have medical licensing reciprocity requirements to file separate Drug Enforcement Agency registration in any state a provider practices to ensure appropriate prescribing for patients through telehealth services; and
- confirm that providers providing telehealth services from home do not have to update their Medicare enrollment addresses.

Finally, to achieve substantial advancements in use of telehealth services, we ask the Administration to work with Congress to remove remaining barriers, such as:

- 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 who 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;
- permanently allow hospital outpatient departments (HOPDs) and critical access hospitals (CAHs) to bill for telehealth services; or, alternatively, clarify the Health and Human Services 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 deliver Medicare telehealth services via audio-only communications when medically appropriate; and
- 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.

Hospital-at-Home Programs

CMS created new opportunities for providers to implement hospital-at-home programs. Specifically, these programs allow approved providers to offer safe hospital-level care to eligible patients in their homes. This has been pivotal in caring for both COVID-19 and non-COVID-19 patients throughout the pandemic. While the initial aim of this flexibility

was to increase health care capacity by keeping patients safely at home during the PHE, the benefits of these programs demonstrate the need to make this a permanent option. Not only have such programs enhanced patient safety, they also have increased access to care and achieved high patient satisfaction. Data are still emerging on the clinical benefits of hospital-at-home programs, but there have been indications of reduced lengths of stay for several types of patients.

Although it is clear that interest in this program among hospitals and health system continues to increase, there is hesitation to stand up a hospital-at-home program without knowing whether that program can continue to exist and serve patients beyond the PHE. Given the safety, access and patient experience benefits provided by this program, AHA anticipates additional provider interest and implementation of hospital-at-home programs if the flexibilities are made permanent.

Workforce

Our staff remain the most important asset in fighting the pandemic and caring for people with any disease or disorder. The pandemic placed enormous demands on their time and talents, and has left many physically and emotionally exhausted. We are looking to eliminate burden for them in any way possible and help prevent burnout. We hope CMS will join in this effort.

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;
- permanently remove certain licensure requirements to allow out-of-state providers to perform telehealth services; and
- allow extensions to residency cap-building periods for new graduate medical education (GME) programs to account for COVID-19-related challenges, such as recruitment, resource availability and program operations.

In addition, we look forward to a continued dialogue with CMS and other agencies on steps we can take to both expand and support our greatest health care asset.

Quality and Patient Safety

We urge CMS to make permanent appropriate changes to the Conditions of Participation (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 advance 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, we urge the agency to:

- 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 grant relief 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;
- continue to allow pathologists and other laboratory personnel to perform certain diagnostic tests and review remotely through a secure network to ensure continued patient access to the best possible care; and
- 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 CAHs, when an emergency requires such action. We also ask that hospitals be held 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, we urge the agency to:

- permanently increase flexibility for site-neutral payment exceptions for providers seeking to relocate HOPDs and other off-campus provider-based departments in order to better and more effectively serve their communities; and
- 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.

Communities rely on America's hospitals and health systems to be there for them in the face of an emergency or disaster, and our work will 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. 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 focus on the health, well-being and wishes of patients.

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 look forward to continuing to work with you to protect the health of our nation.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy

Cc: Lee A. Fleisher, M.D., Director, Center for Clinical Standards and Quality