

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. These actions included the Centers for Medicare & Medicaid Services (CMS) waiving several regulatory requirements and Congress providing significant legislative and financial support to ensure hospitals and health systems could manage the numerous challenges facing them. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

Hospitals and health systems utilized these newly authorized resources and flexibilities to increase capacity, separate areas of care for COVID-19 and non-COVID-19 patients, expand testing and telehealth capabilities, and mitigate workforce challenges. While these new tools were created as a direct response to the COVID-19 public health emergency (PHE), this process also acted as a catalyst for establishing new, innovative and safe ways for our members to deliver patient-centered care.

## AHA Take

While the pandemic may be entering a new phase, one where hospitals and health systems are focused on recovery and rebuilding, the entire health care system continues to be under considerable strain and intense financial instability. Changes in workforce availability, rapid inflation, broken supply chains and sicker patients are challenging hospitals' ability to meet the needs of their communities. The flexibilities granted because of the COVID-19 PHE resulted in significant benefit to patient care during an extreme situation and are needed now more than ever to continue that support to patient access to high-quality care.

Recognizing both the immediate and potential long-term benefits of these flexibilities, we urge Congress to pass legislation to make certain flexibilities permanent while supporting a post-COVID-19 PHE transition period for several others. Without Congressional action, these flexibilities will cease to exist once the PHE ends and/or sunset shortly after the COVID-19 PHE is terminated.

### Telehealth

Many of the following telehealth flexibilities were extended by Congress for 151 days beyond the expiration date of the COVID-19 PHE. **We urge Congress to make these waivers permanent, as they represent critical advancements in care delivery.**

- Eliminate the originating and geographic site restrictions for all telehealth services.
- Allow rural health clinics and federally qualified health centers to continue to serve as distant sites for all telehealth services beyond mental health services.
- Expand telehealth eligibility to certain practitioners, such as respiratory, physical, occupational and speech language therapists.
- Allow providers to deliver all Medicare telehealth services (beyond mental health services) via audio-only communications when medically appropriate.
- Allow hospice and home health professionals to deliver telehealth services and qualify telehealth, including audio-only, visits to meet existing face-to-face requirements.
- Allow direct supervision through telecommunications technology for specified services.
- Allow hospital outpatient departments (HOPDs) and critical access hospitals 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.

- 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.
- Ensure remote patient monitoring is treated similarly to other existing telehealth flexibilities in terms of coverage.
- Eliminate the current separate consent process for telehealth services and use the telehealth encounter as presumed consent.
- 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.

## **Hospital at Home**

We urge congress to consider the Hospital Inpatient Services and Modernization Act that would extend the program for two years beyond the expiration date of the COVID-19 PHE and has been introduced in both the House (H.R.7053) and Senate (S.3792). Passage of this legislation would provide the necessary bridge for the development and implementation of a permanent hospital-at-home program.

The program has proven to be successful to both patients and hospitals and health systems which allowed for increased capacity while keeping patients safely in their own homes.

## **Workforce**

- Permanently eliminate specific nurse practitioner practice limitations 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. This provision, like others in the telehealth section above, was temporarily extended for 151 days after the COVID-19 PHE is terminated.
- Allow extensions to residency cap-building periods for new graduate medical education programs to account for COVID-19-related challenges, such as recruitment, resource availability and program operations.

## **Quality and Patient Safety**

- Make permanent appropriate changes to the conditions of participation (CoPs), such as reconsidering use of verbal orders, as well as modifying confusing or unhelpful discharge planning requirements, with a focus on better equipping providers to assist patients in the most meaningful way possible.
- 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, for some period of time beyond the COVID-19 PHE, 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 influxes of COVID-19 and non-COVID-19 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.
- 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**

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