

SUPPORTING HOSPITALS TO DELIVER PATIENT CARE IN COVID-19 SURGE

- **EMTALA**: In addition to the EMTALA waivers that CMS has granted, greater EMTALA flexibility would allow hospitals to better manage patient surge. For example:
 - Hospitals should be permitted to set up alternate screening locations off the hospital campus and redirect patients to that location. This will expand surge capacity and minimize exposure for health care workers and non-COVID patients.
 - Patients should be permitted to remain in their car while receiving a medical screening examination (MSE) and download an app on their phone for further communication with the hospital. This will avoid having to disinfect hospital iPads/tablets after each patient and reduce the risk of greater community spread.
- **Medical Staff Bylaws**: Suspend enforcement of conditions of participation (CoPs) for medical staff bylaws (under 42 CFR § 482.22) so that MSEs can be performed by other qualified medical staff authorized by the hospital, such as register nurses, who are acting within their scope of practice and licensure, yet are not designated in the bylaws to perform MSEs.
- **Scope of Practice**: Waive any scope of practice limitations to enable all practitioners to practice to the full extent of their training and help alleviate health care workforce shortages.
- **Alternate Care Sites**: Waive CoPs, conditions of coverage, licensure, and life-safety code requirements to permit hospitals to use alternate care sites (hospital or non-hospital owned) to expand surge capacity. For example, hospitals should be permitted to use:
 - Empty space on a floor of a hospital that is, or has previously been, used and licensed for another non-hospital type of care;
 - Hospital space certified for a non-hospital purpose, such as the hospital cafeteria or conference rooms;
 - Off-campus medical office building not owned by a hospital;
 - Existing hospital infrastructure, such as a hospital tower, closed hospital wings, and unlicensed beds that are currently closed and may be unlicensed and not compliant with current life safety and building codes.
- **Physician Self-Referral Law**: Issue a blanket waiver of the physician self-referral law, rather than requiring case-by-case waiver requests by individual hospitals. A blanket waiver for financial relationships that are related to managing the COVID-19 emergency would ensure an adequate health care work force and maximize hospital operational flexibility. Case-by-case waivers will divert valuable CMS and hospital time, energy, and resources away from managing COVID-19 and other patients during this national emergency.
- **Prior Authorization**: Suspend Medicare Advantage plans' use of prior authorization requirements and other medical management tools. Prior authorization and medical management tools delay access to care due to processing, determinations, and appeals,

leaving patients and providers in limbo. The use of such tools related to post-acute care result in the unnecessary utilization of vital inpatient hospital bed capacity that may shortly become scarce due to the COVID-19 surge.

- Discharge Planning Requirements: Suspend hospital discharge planning requirements, including the requirement to provide patients extensive quality data regarding post-acute providers at discharge (42 C.F.R. §482.43(c)).
- Patient Choice: Suspend patient choice requirements and CoPs during the time of the COVID-19 emergency so that hospitals may quickly and appropriately move patients to post-acute providers who have the capacity, capability, and willingness to take patients.
- Inpatient Rehabilitation Facility (IRF) 3-Hour Rule: Suspend the inpatient rehabilitation facility (IRF) 3-hour rule for the provision of therapy, the “preponderance” of which must be one-on-one, so that more patients can be moved to licensed IRFs, freeing up vital inpatient capacity. In addition, CMS should provide additional flexibility to allow free-standing IRFs to accommodate patients from an acute care hospital, while not affecting the requirements to receive payments as an IRF under the 60 percent rule.
- Long-Term Care Hospitals (LTCHs): Waive the 3-day intensive care unit (ICU) requirement for LTCH-compliant patients.
- Home Health: Suspend the requirement for physicians to evaluate patients face-to-face for home health admission to facilitate efficient discharges for patients who no longer need acute care. Waive the requirement that a beneficiary must be home bound in order to receive home health services. This will free up clinical staff to focus on the highest-acuity patients.
- Medical Record Requirements: Lengthen the current 30-day requirement to complete medical records after a patient’s discharge and the 48-hour requirement to authenticate verbal orders. This will free up additional time for physicians to remain at the bedside rather than behind a desk.
- Verbal Orders: Allow verbal orders to be used more than “infrequently” and allow authentication to occur later than 48 hours. This will allow physicians to prioritize how they allocate their time to best treat ill patients during this surge situation. (42 CFR §482.24)
- Medical Staff: Allow physicians whose privileges will expire during the emergency period, and new physicians, to practice before full medical staff/governing body review and approval. This will keep clinicians on the front line and allow hospitals and health systems to prioritize patient care needs during the emergency. (42 C.F.R. §482.22(a))

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- **IRFs, LTCHs and IPFs:**
 - Waive post-acute pre and post-admission clinical assessment requirements
 - Delay reporting and submitting timelines for the IRF Patient Assessment Instrument (IRF-PAI) and LTCH Continuity Assessment Record and Evaluation (CARE) Tool
- **Telehealth:**
 - Waive telehealth requirements to permit hospitals to conduct telehealth in a flexible manner. For example, hospitals could conduct a telehealth visit from an infection-free zone of a hospital with a COVID-inpatient, or a pathologist may conduct telehealth from the physician's home
 - Support legislation to remove the current requirement of an established patient-provider relationship within the last three years. By expanding telehealth, we reduce exposure to our health care workforce.
- **Preserving Personal Protective Equipment (PPE):** Waive sterile compounding requirements at 42 C.F.R §482.25 (b) and United State Pharmacopeial Convention (USP) 797 allow practitioners performing sterile compounding to remove, retain, and re-don face masks in the compounding area during the same work shift to conserve scarce supplies.
- **Quality Reporting Requirements:** Suspend quality measure reporting requirements and timelines across all acute, ambulatory and post-acute care quality reporting programs, including but not limited to the Hospital Inpatient Quality Reporting (IQR) program, the Hospital Value-Based Purchasing (VBP) program, the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Conditions (HAC) program, the Ambulatory Surgical Center Quality Reporting Program (ASCQRP) and the Merit-based Incentive Payment System (MIPS), the Inpatient Psychiatric Facility (IPF) quality reporting program and all post-acute care quality reporting programs. Consider delaying implementation of the Standardized Patient Assessment Data Elements (SPADE) data collection scheduled for October 1, 2020 due to delays that will occur in staff training and infrastructure development related to the successful collection and reporting of data.
- **Advance Payments:** Immediately direct the Medicare Administrative Contractors (MAC) to streamline the process and prepare for numerous hospital and other provider requests for advance payments to mitigate any disruption in claims processing and cash flow and help ensure normal hospital operations during the crisis.
- **Audits:** Suspend all Medicare fee-for-service pre- and post-payment automated and complex review audits, including but not limited to those conducted by Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIP), MAC and the Quality Improvement Organizations (QIOs) to free up physicians and other clinical staff to be focused on patient care and not administrative reviews.

- Credentialing: Suspend the requirement for primary sourcing of certain credentialing information (under CoP 482.12(a)(6)); secondary sourcing of information would continue but primary sourcing would occur after returning to normal hospital operations. This will allow continued privileging of providers and assist in ensuring access to care.
- HIPAA: Extend the current HIPAA privacy regulation waiver beyond the 72-hour limit given the extend nature of this pandemic.
- Other:
 - Suspend all Worksheet S-10 audits and allow additional time for providers to meet cost report submission deadlines among other reporting requirements not essential to patient care and which would divert hospital resources from the COVID-19 crisis.
 - Delay the April 1, 2020 requirement for full production implementation of systematic validation edits for the Outpatient Prospective Payment System (OPPS) providers with multiple service locations related to address reporting.
 - Clarify that providers do not have to notify the State Survey Agency and CMS Regional Office if operating under a COVID-19 blanket waiver.