Charles N. Kahn III
President and CEO

July 27, 2022

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

Dear Secretary Becerra:

The Federation of American Hospitals (FAH) is the national representative for more than 1,000 tax-paying community hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

We commend your leadership and support of hospitals as they continue to address patient needs throughout the COVID-19 public health emergency (PHE). The numerous regulatory waivers and legislatively mandated waiver policies have been absolutely essential in enabling hospitals to manage patient care challenges associated with the relentless cycle of COVID-19 related patient surges throughout the PHE.

While we all long for the day when we can declare the emergency over, that day is not yet in sight for America's hospitals. So, we urge you in the strongest terms possible not just to renew the current PHE (which is set to expire in October) for an additional 90-day period, but to send a clear signal that an additional 90-day extension may be necessary. This is critical to prevent unintended consequences to our health care system that would result from seeking shortcuts to a smooth and responsible transition out of the sustained COVID-19 crisis.

Combatting COVID-19 for well over two years has left deep and structural problems for health care delivery generally, though the damage has been mitigated in part by the extraordinary resilience of our dedicated workforce as well as the swift and sustained support of Congress and the Administration. Meanwhile, COVID-19 cases, deaths, and hospitalizations are again on the rise. New variants continue to emerge. And a new vaccine is unlikely to be available until the fall at the earliest, which will take months to administer and achieve critical mass. Considering this

reality, it would be nothing short of tragic for hospitals and the millions of Americans who rely on them for care if the Administration were to withdraw needed support through a premature termination of the PHE.

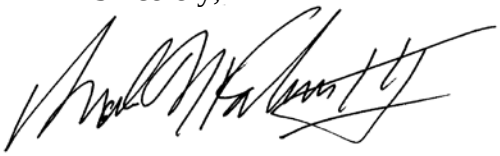
As you know, the PHE is foundational to the extensive administrative flexibilities that are critical for meeting patient needs and caring for COVID-19 and non-COVID-19 patients. Many of the waivers have been transformational for our health care system -- incentivizing new technologies to modernize and redesign how care is delivered, while accelerating adoption of alternative care models that increase efficiency and quality. The workforce waivers in particular have been especially critical as hospitals struggle through a persistent, chronic labor shortage.

Equally important, beyond these waivers, several crucial health care coverage and hospital payment policies enacted by Congress are linked to the PHE. For example, when the PHE ends, states will resume Medicaid coverage redeterminations which are estimated to result in millions of Americans losing coverage. In addition, the 6.2 percent increase in the federal Medicaid match rate (FMAP) for states, which has helped fortify fragile state programs, would end. Also ending are the 20 percent DRG add-on for COVID patients, as well as the New COVID-19 Treatments Add-On Payment (NCTAP), both of which are needed to help defray the high costs of care for these patients. There is no understating how vital these policies are, and why the PHE matters.

Indeed, the PHE has already served as a bridge to CMS' efforts, which we strongly endorse, to transform certain temporary waivers into permanent Medicare policy, some of which may require Congressional action to avoid any disruptions. **Attached is a list of key PHE waivers and other policies that we urge CMS to act upon for permanent Medicare policy status.**

We appreciate your dedication and the momentum the entire Administration has generated as we strive to manage the COVID-19 menace. Towards that end, we look forward to continuing our work together to ensure that hospitals can continue to provide quality care to their patients during this PHE and apply "lessons learned" to transform and modernize Medicare policies. Please feel free to contact me or any member of my staff to discuss further these important matters at (202) 624-1534.

Sincerely,



CCs: The Honorable Chiquita Brooks-LaSure
Jonathan Blum
The Honorable Dawn O'Connell
Rochelle P. Walensky, MD, MPH
Ambassador Susan E. Rice
Ashish K. Jha, MD, MPH
Christen L. Young

Attachment

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PHE WAIVERS AND OTHER POLICIES THAT SHOULD BE PERMANENT

Remote Services Provided Through the Use of Technology

- **At Home HOPD Services**: Allow Medicare payment for certain HOPD services provided in the patient home or other setting (*e.g.*, partial hospitalization program services (PHP); independent/group therapy; congestive heart failure clinic services), with payment under the outpatient prospective payment system as if the service had been furnished in the HOPD.
- **Geographic and Originating Site**: Eliminate the Medicare telehealth geographic and originating site restrictions to allow these services to be provided via urban hospitals, physician offices, and patient homes in any area of the country.
- **Eligible Practitioners**: Expand the list of eligible practitioners who may furnish clinically appropriate health care services via remote technology, including licensed professional counselors (LPCs).
- **Expanded Medicare Physician Fee Schedule (MPFS) Coverage/Payment**: Continue expanded coverage/payment under the MPFS, including:
    - **Physician or advanced practice practitioner** (APP) services (*e.g.*, physician/APP consults for patients in the emergency department, critical care services, therapy services, and initial and continuing intensive care services).
    - **Remote patient monitoring** (RPM) for new or established patients with any single chronic or acute conditions, including monitoring a patient in their home post-surgery to help avoid hospital readmissions.
    - **Virtual check-ins and e-visits** when furnished to new patients.
    - **Audio-only E/M services** for audio-only E/M (CPT 99441-99443), with an appropriate payment differential.
    - **Direct supervision** requirement is satisfied by the virtual presence of a physician (for purposes of "incident to" and "teaching physician" services) through audio/video real-time communications technology.
    - **Resident services under the primary care exception** allowed for an expanded list of services, including audio-only evaluation and management, e-visits, inter-professional consultations, transitional care management, virtual check-ins, and remote evaluations.
- **Hospice and Home Health Telehealth**: Allow professionals who provide hospice and home health services to do so via telehealth and grant these professionals the ability to meet face-to-face requirements via virtual visits, including audio-only visits.

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- **DEA Registration Exception**: 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.
- **Qualified Medical Personnel (QMP)**: Permit QMPs to perform medical screening examinations (MSEs) via telehealth; permit the QMP to be on-campus or offsite (due to staffing shortages) but must be performing within the scope of their state scope of practice act and approved by the hospital's governing body to perform MSEs.
- **Rural Health Clinics/Federally Qualified Health Centers**: Allow Medicare payment for telehealth services furnished in rural health clinics and federally qualified health centers, and work with stakeholders to support fair and appropriate payment for these safety net providers.
- **Waiver of Frequency Limits**: Allow subsequent hospital care services and critical care services to be furnished via telemedicine without limiting these telehealth services to once every three days, or once per day, respectively.
- **In-State Licensure Flexibility**: Allow licensed out-of-state physicians/non-physician practitioners (NPPs) to provide telehealth to patients across state lines without having to obtain licensure in the state where the patient is located (while recognizing that state waivers or licensure compacts also would be needed.)
- **Relaxation of Credentialing by Proxy Written Agreement Requirement**: Allow a spoke hospital to rely on the credentialing decisions (for a telehealth physician) of a distant site hub hospital, with no written agreement, to memorialize that the hub hospital fulfilled all the hospital conditions of participation (CoP) requirements for credentialing and privileging.

Clinical Services

- **Nursing Staff**: Remove requirement for nursing staff to maintain a comprehensive care plan as this is an antiquated and redundant requirement that detracts from the nursing staff's care of the patient; alternatively, the nursing care plan could focus on several key patient problems at issue during the patient's hospital stay, while the clinical medical record would instead represent the entire care plan and related medical interventions.

Lab Services

- **Pathology Review**: Allow pathologists to review pathology slides remotely without the need for a separate CLIA certificate for the remote location.
- **COVID-19/Influenza Lab Testing**: Allow Medicare payment for COVID-19 (and influenza) and related diagnostic lab testing without an order from a treating physician/APP.

Discharge Planning

- **Patient Choice Requirement**: Regulatory discharge requirement that providers must furnish a list of home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient

rehabilitation facilities (IRFs) and long-term-care hospitals (LTCHs) that are available to the patient should be permanently streamlined. We urge CMS to work with affected stakeholders to establish appropriate regulatory guardrails that achieve a balance of protecting patient choice and ensuring access to appropriate levels of high-quality care with the need for specific information that is most beneficial for patients when being discharged to post-acute care facilities.

Behavioral Health

- **Advanced Practice Nurse**s: Allow advanced practice nurses to serve in the attending role for Medicare patients, *e.g.*, diagnose, treat, admit patients with mental illness, and not require physician supervision.
- **Discharge Planning**: Remove discharge planning requirements for post-acute care from psychiatric facilities since patients typically are not transferred from psychiatric facilities to post-acute care providers.

Physician Self-Referral / Medicare Antikickback Statute (AKS)

- **Physician Self-Referral and AKS**: Physician self-referral and AKS waivers should be available as a blanket waiver in future PHEs, rather than seeking a waiver on a case-by-case basis. In addition, we urge implementation of at least a one-year wind down period to ensure enough time for hospitals and physicians to assess and make appropriate changes to arrangements made pursuant to a current COVID-19 waiver.

Workforce

- **Restrictive Practice Limitations**: Permanently eliminate specific practice limitations on nurse practitioners that are more restrictive under CMS rules than under state licensure.
- **Graduate Medical Education (GME) Programs**: Allow extensions to residency cap-building periods for new GME programs to account for COVID-19-related challenges, such as recruitment, resource availability, and program operations.

Increased Capacity

- **Site-Neutral Payment Exception**: 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.
- **Rural Area Bed Capacity**: 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.