Washington State Hospital Association

Oregon Association of Hospitals and Health Systems

May 23, 2022

Dear Secretary Becerra:

We appreciate that the Centers for Medicare and Medicaid Services have sought information about the federal law waivers most critical to hospitals' ongoing response to the COVID-19 pandemic. The Washington State Hospital Association (WSHA) and the Oregon Association of Hospitals and Health Systems (OAHHS) have been reviewing the unwinding process and hope this letter provides useful, current information on our areas of concern.

We were pleased to see your announcement last month that the Public Health Emergency (PHE) would be extended for another 90 days, and we appreciate that the Agency is working hard to understand the implications of the post-PHE time period.

At stake are the future of the many federal law waivers and regulatory flexibilities on which hospitals are relying to manage patient surges and other care delivery challenges stemming from the pandemic. During the PHE, some of our hospitals also responded to other emergencies such as those related to fires, reminding us that the importance of these flexibilities is not limited to the pandemic. We want to make sure that the Department of Health and Human Services (HHS) is aware that the effects of the pandemic have not abated for patients who need access to acute hospital care and the healthcare workforce providing that care. Many of our hospitals continue to operate at over 100 percent capacity on a routine basis. Hospitals are experiencing increased demand in part due to cancelations of scheduled procedures, surgeries, and services and they continue to be faced with challenges such as staffing shortages and supply chain disruptions. The lack of post-acute beds and staffing shortages also mean that we are unable to discharge patients in need of post-acute care, exacerbating boarding of patients.

Every day in Washington state and Oregon hospitals continue to rely on key waivers to get patients the care they need when they need it. With this as background we respectfully seek your support for a process that ensures the waivers and regulatory flexibilities associated with the PHE are not abruptly curtailed, but instead are thoughtfully transitioned with sufficient lead time and processes to allow hospitals to continue to meet important needs of their patients and healthcare workers. We urge careful consideration of each waiver and request that certain waivers either become permanent or be ramped down as capacity to provide lifesaving acute care for patients increases.

With this letter we would like to provide our federal partners with a prioritized list of waivers and regulatory flexibilities the hospitals of Washington state and Oregon have identified as necessary to continue meeting the acute care needs of our patients.

Make Telehealth Changes Permanent. From the perspective of our patients and direct care providers perhaps the most positive and impactful care delivery changes to come from the pandemic are improvements to telehealth delivery. We are happy that the Consolidated Appropriations Act for Fiscal Year 2022 includes important provisions to extend and expand telehealth flexibilities for 151 days after the end of the Public Health Emergency and realize Congress will need to address statutory changes to make permanent change. We hope the Administration will share our support for this request and seek such a change**.**

Among the critical benefits, the extension means:

- The originating site of care will continue to include any site at which the patient is located, including the patient's home;
- Practitioners eligible to furnish telehealth services will include occupational therapists, physical therapists, speech-language pathologists and audiologists;
- Federally qualified health centers and rural health clinics can furnish telehealth services;
- Delaying the six-month in-person requirement for mental health services furnished through telehealth until 152 days after the emergency. This includes the in-person requirements for federally qualified health centers and rural health clinics;
- Extending coverage and payment for audio-only telehealth services;
- Extending the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care; and
- Requiring the Medicare Payment Advisory Commission to conduct a study on the expansion of telehealth services and the Department of Health and Human Services Secretary to publicly post data with respect to telemedicine utilization.

Making these waivers permanent is essential so we can protect access to vital telehealth services for patients. We also will continue to advocate that critical access hospitals have the flexibility to continue providing telehealth care for patients and communities, especially behavioral health services.

Preserving Acute Care Capacity by Facilitating Patient Discharge. Washington and Oregon have the lowest number of acute care beds per capita in the nation. Acute care space is a precious resource. In Washington, exacerbating the shortage of acute care beds is a state agency interpretation of federal law on consent to placement into long term care that is resulting in hundreds of discharge-ready patients being backed up for weeks or months into acute care beds. In order to preserve acute care space for those patients who most need it, Washington and Oregon hospitals request the continuation of key federal waivers.

- ***3-Day Prior Hospitalization***. Continue to waive the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, continue to authorize SNF coverage without first having to start a new benefit period.

- ***Discharge Planning***. CMS should permanently waive the requirements within the CoPs at 42 C.F.R. §§ 482.43(a)(8), 482.61(e), 485.642(a)(8) to allow hospitals to discharge patients who no longer need acute care based solely upon which post-acute providers can accept them. In addition, CMS should permanently waive documentation requirements for transfers to post-acute care (42 C.F.R. § 482.43).

- ***Pre-Admission Screening and Annual Resident Review (PASARR).*** Continue to waive 42 CFR § 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Under this permission, Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) are referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.

Allow Hospitals to Offer Long-term Care Services ("Swing-Beds") Where Necessary. In a case where hospitals must continue to provide services to patients who no longer require acute care, we request continuation of waivers to allow acute care hospitals to operate swing-beds for patients who do not require acute care but do meet the skilled nursing facility (SNF) level of care criteria as set forth at 42 CFR § 409.31. This needed flexibility will allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for patients who no longer require acute care, but due to capacity limitations and other shortages are unable to find placement in a SNF.

Ensure Rural and Critical Access Hospitals Can Respond to Surges and Delivery Pressures. One of the great pandemic successes in Washington State and Oregon has been hospitals' ability to level-load patients as an effort to ensure those who need life-saving acute care can receive it. Rural hospitals played a critical role in this process by caring for patients who would normally be transferred to larger facilities in-house. They provided higher levels of care with support from experts via telehealth. In order to keep this release-valve open, we urge CMS to continue to support increased bed capacity for critical access hospitals (CAHs) and take other actions to support enhanced care in rural areas. We encourage CMS to permanently waive the 96 hour length of stay limitations on CAHs, and, post-PHE, create additional flexibility for CAHs to exceed 25 beds as community needs arise that result in abnormally high acute care demand. We also urge CMS to permanently increase flexibility for site-neutral payment exceptions for providers seeking to relocate hospital outpatient departments and other off-campus provider-based departments in order to better and more effectively serve their communities.

Support a Robust Workforce. Throughout the pandemic we experienced the direct tie between patient access to care and maintaining an adequate workforce to provide the care. We request that CMS permanently retain waivers that enable advanced practice clinicians and other health care professions to practice at the maximum of their state licensed scope of practice. Permanently removing outdated CMS regulatory barriers to licensed non-physician practitioner practice in hospitals is critical to fully utilizing our available health care workforce. We also encourage continued 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.

Administrative Simplification. It is widely acknowledged that administrative burdens and paperwork are one of the biggest factors in caregiver burnout and can slow delivery of patient care. We request that CMS permanently waive the requirements within the CoPs at 42 C.F.R. §482.24 to allow regular use of verbal orders. Allowing the use of verbal orders will allow facilities to triage, screen, stabilize, and treat patients more efficiently and effectively. Verbal orders could be permitted with read-back verification and with authentication to follow within a reasonable time. In addition, we support the ability to transmit orders through text applications with subsequent verification and authentication in the same fashion as these verbal orders.

Make Hospital-at-Home Programs Permanent. To allow for hospitals and health systems to increase capacity and keep patients as safe as possible, CMS took action to expand accessibility to hospital at home programs. Multiple Washington state and Oregon hospitals have invested in development of Hospital at Home programs relying on CMS waivers to do so. CMS waived section 482.23(b) and (b)(1) of the CoPs, which require nursing services to be provided on premises 24 hours a day, seven days a week, and the immediate availability of a registered nurse for care of any patient. These programs hold great promise for both benefiting patients and freeing up acute care hospital beds for those who need to be in a facility. We urge continuation of this program so as to not lose the momentum associated with this new care delivery model. The Hospital Inpatient Services Modernization Act is bipartisan legislation that would extend the acute hospital care at home waiver program two years beyond the end of the COVID-19 PHE. WSHA and OAHHS join the American Hospital Association in urging action to advance this legislation. We hope the Administration will share our support for this legislation.

Sincerely,

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Becky Hultberg
President & CEO, OAHHS

cc:
Ingrid Ulrey, HHS Region 10 Director
Senator Maria Cantwell
Senator Jeff Merkley
Senator Patty Murray
Senator Ron Wyden
Congressman Cliff Bentz
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