



Minnesota Hospital Association

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April 17, 2023

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Ave SW, Room 509F  
Washington, DC 20201

***Submitted electronically***

**RE: End of the COVID-19 Public Health Emergency Declaration**

Dear Secretary Becerra,

On behalf of our member hospitals and health systems, the Minnesota Hospital Association (MHA) urges the Department of Health and Human Services (HHS) to consider the following comments on the impact of ending the federal public health emergency (PHE) on May 11, 2023.

Over the past three years, hospitals and health systems have been on the front lines of combating the COVID-19 pandemic and have needed to rework countless policies and procedures to adjust to shifts in patient care. However, despite current low COVID-19 infection rates, hospitals and health systems are still facing long-term operational challenges due to the health care workforce shortage and increased costs of labor and supplies. MHA is concerned that the end of the PHE will only exacerbate the ongoing instability that many hospitals and health systems face, especially in rural areas. HHS should work with Congress to ensure the following flexibilities are extended or made permanent, to ensure hospitals and health systems can continue to recover and adjust to the current financial environment and provide high-quality patient care.

**96 Hour Rule for Critical Access Hospitals (CAHs)**

The Centers for Medicare and Medicaid Services (CMS) temporarily waived the Medicare requirement that CAHs limit their number of beds to 25, and that the average length of stay is not more than 96 hours. By easing the 96-hour rule during the PHE, CAHs could be more flexible in admitting patients and waiting for transfers or discharge, especially given the unique hospitalization needs of COVID-19 patients. HHS already deprioritized the requirement in 2018 due to the unintended financial burden on CAHs, and MHA is concerned about the ambiguity of enforcement discretion once the PHE expires. CAHs currently need more flexibility for length of stay requirements, since Minnesota hospitals and health systems are experiencing significant discharge delays to post-acute care facilities. In one recent month alone, seniors in Minnesota were denied admission to nursing homes or assisted living settings 11,000 times. **MHA urges HHS to extend their enforcement discretion of the 96-hour rule, in hopes that Congress will repeal the requirement permanently to better adjust to the evolving needs of our rural communities.** This policy change would also preserve patient access to hospital care in smaller, rural communities.

**Three-Day Prior Hospitalization for Post-Acute Care**

During the PHE, CMS temporarily waived the requirement for a three-day prior hospitalization for Medicare coverage of a skilled nursing facility stay. **MHA is concerned that reinstating this**

**requirement will further stretch strained hospital capacity and urges an extension of this waiver.** Minnesota's hospitals and health systems are experiencing a significant uptick in the number of individuals seeking care in emergency rooms. Some of these patients end up boarding in the emergency room as they wait for an inpatient bed, creating additional delays and wait times for other patients who need emergency care. Recent MHA data found that in one week alone, nearly 2,000 patients were eligible for transfer to a continuing care setting but could not be discharged from the hospital due to lack of capacity. This backlog may get worse if more patients are required to stay in the hospital for three days before being transferred to a post-acute care facility.

## **Telehealth**

The telehealth flexibilities instituted in Medicare due to the PHE have been invaluable in expanding access to critical health care services and helping mitigate the provider workforce shortage, especially in rural Minnesota. MHA is grateful for the extension of many of these important flexibilities through December 2024 and urges HHS to work with Congress to make permanent Medicare reimbursement for telehealth services provided to patients at home. In addition, the following telehealth policy implications are important for hospitals and health systems:

- *Reporting Home Address:* When the PHE ends, telehealth practitioners will be required to report their home address on the publicly available Medicare enrollment record. MHA members are concerned about the impact of this requirement on the privacy and safety of their providers. This requirement will also impose additional administrative burdens for both providers and their health care facilities.
- *Virtual Cardiac and Pulmonary Rehabilitation Programs:* During the PHE, CMS temporarily allowed Medicare reimbursement for cardiac and pulmonary rehabilitation programs provided or supervised virtually in a patient's home. This telehealth service has been shown to reduce hospital readmissions and should be permanently added to the Medicare Telehealth Services list.
- *Partial Hospitalization Program Services:* During the PHE, hospitals could provide and bill Medicare for individual psychotherapy, patient education, and group psychotherapy services provided via telehealth in a patient's home. By ending this flexibility, patients may not preserve the continuity of care in their partial hospitalization programs, potentially leading to increased inpatient admissions.
- *Virtual Prescribing of Controlled Substances and Buprenorphine:* MHA is concerned that the recent Drug Enforcement Administration proposed rules will negatively impact patient-provider relationships established over the past three years, potentially jeopardizing access to necessary care for vulnerable patients. While we understand guardrails to virtual prescribing may be necessary to limit bad actors, we do not believe the proposed requirements for an in-person visit is the right approach. Instead, as noted in our public comments on the proposed rules, we urge HHS to work with the Department of Justice to consider proposing a special registration process for providers to have the ability to continue to prescribe medically necessary controlled substances and buprenorphine via telehealth.

## **340B Drug Pricing Program**

Many of the 95 hospitals in Minnesota that participate in the 340B Drug Pricing program have experienced significant financial and operational challenges throughout the pandemic that may have affected their program eligibility. One of the primary eligibility criteria for hospitals in the 340B program is the Medicare disproportionate share hospital (DSH) patient percentage, based on a hospital's volume of inpatient Medicaid and Medicare patients. With so many emergency and non-

urgent care changes due to fluctuating rates of infectious diseases, ongoing program flexibility is essential to protect 340B drug savings for hospitals that may have become ineligible due to the pandemic's impact on hospital patient mix. Further compounding the problem is that the program is coming under attack from drug manufacturers placing unlawful restrictions on covered entities, negatively impacting hospitals and the ability to acquire prescription drugs at a discount, mitigate reimbursement shortfalls, and provide services to their communities.

MHA is also concerned about the impact of the Medicaid redetermination and renewal process that has now resumed in Minnesota. Since the start of the COVID-19 pandemic, statewide enrollment in Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare (Minnesota's Basic Health Plan) has grown by more than 354,000, or 30%, to over 1.5 million people. If enrollees lose coverage for any reason, it may impact the DSH patient percentage at some hospitals. Congress has already enacted a provision to allow hospitals that may have lost their eligibility during the PHE to be reinstated into the 340B program. **MHA urges HHS to work with Congress to extend the 340B eligibility protections to account for the unprecedented fluctuations in public program enrollment and provide additional time for stabilization.**

### **COVID-19 Data Reporting Requirements**

While hospitals and health systems understand the importance of sharing COVID-19 data with HHS, the end of the PHE is an appropriate opportunity to review and streamline current data reporting requirements. MHA members have been compliant with the many intense federal reporting requirements throughout the pandemic, but many have struggled to maintain the internal capacity and processes required for additional administrative burdens. Currently, the hospital COVID-19 related reporting is required through April 2024, however **HHS and CMS should consider allowing the current COVID-19 data reporting Medicare Condition of Participation to expire at the end of the PHE.** Hospitals and health systems are ready and willing to collaborate on streamlined data reporting requirements for infectious diseases moving forward.

### **Hospital at Home**

Minnesota is one of 34 states that is approved for the CMS Acute Hospital Care at Home waiver program. The program is a critically important tool that has allowed hospitals and health systems to provide safe, high-quality care in the comfort of the patient's home. To ensure continuity of innovative patient-centered care, **CMS should extend the existing waiver program beyond 2024 and work with Congress to establish a permanent program.**

MHA reiterates the significant impact that the end of the public health emergency will have on hospitals and health systems, particularly on both short-term and long-term financial stability. We appreciate your consideration of our comments and please feel free to contact me with any questions.

Sincerely,

*R. Koranne.*

Rahul Koranne, M.D., MBA, FACP  
President & CEO

CC: The Honorable Amy Klobuchar, The Honorable Tina Smith, The Honorable Brad Finstad, The Honorable Angie Craig, The Honorable Dean Phillips, The Honorable Betty McCollum, The Honorable Ilhan Omar, The Honorable Tom Emmer, The Honorable Michelle Fischbach, The Honorable Pete Stauber