June 23, 2020

The Honorable Lamar Alexander, Chairman
The Honorable Patty Murray, Ranking Member
U.S. Senate Committee on Health, Education, Labor and Pensions
430 Dirksen Senate Building
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

The Healthcare Leadership Council (HLC) commends the Senate Committee on Health, Education, Labor and Pensions for holding its hearing on, "COVID-19: Lessons Learned to Prepare for the Next Pandemic." We applaud the promptness with which you and your colleagues in the U.S. Senate and House of Representatives have addressed policies and priorities related to disaster preparedness under these extraordinary circumstances.

The HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach. We are uniquely positioned to address disaster preparedness comprehensively from all perspectives in the healthcare industry.

HLC members are pleased to announce that we are working with the Duke-Margolis Center for Health Policy on an initiative aimed at strengthening the public-private partnership that is essential to disaster preparedness and response. As part of this initiative, as we are also working with the Deloitte consulting firm to bring its expertise to our endeavor.

Like you, we believe there is much to be learned from the collective response thus far to the COVID-19 pandemic. In the summer and fall of 2020, we will be bringing together the expertise of the Duke-Margolis Center, the multisector perspectives of the HLC membership, and ideas from key individuals and organizations – from the public sector as well as the Administration and Congress – involved in the current pandemic response to assemble a set of innovative, integrated solutions that will, one, determine what is working well in the current COVID-19 response and needs to be maintained and even strengthened and, two, what aspects of our disaster preparedness and response require fresh thinking and new approaches.

Our work will be concentrated in three primary areas:

- **Supply chain readiness.** Particularly in the early stages of the COVID-19 pandemic, we witnessed difficulties and disruptions in the distribution of critical goods and supplies including personal protective equipment and testing supplies. It is essential that we call upon the expertise of the private sector to build a disaster-ready supply chain that can work with government at all levels to ensure that our nation[‘s needs are met and that future treatments and vaccines can be delivered safely and expeditiously.

- **Care delivery.** We have learned a great deal during the current pandemic about how to expand healthcare reach to meet extraordinary escalations in patient demands. It is essential to translate those lessons into a systemic approach that incorporates components such as telehealth, workforce mobility, adequacy and resiliency, and financial stability for healthcare providers during periods when normal revenue streams are disrupted.

- **Data and evidence generation.** Our ability to respond to a nationwide health crisis relies heavily on the ability to access and analyze data rapidly and effectively. This must involve well-coordinated public-private cooperation to gather data and utilize it to improve patient care, strengthen public health surveillance, and accelerate biomedical innovation while protecting the privacy of individuals.

Through this initiative, contributions from the nation’s premier experts in both healthcare and disaster preparedness will be coalesced into a set of specific recommendations and commitments that will strengthen our nation’s preparedness and response for future health crises. We will be sharing ideas with your committee as this initiative progresses.

Legislative Priorities

In addition to the broad-based policy initiative mentioned above, HLC members also urge your committee and others in Congress to address a set of legislative actions that will help reduce barriers to disaster preparedness and response. These legislative priorities are outlined below.

Workforce

- Implement a federal waiver of state licensure and allow for practice at the top of the scope of license for physicians, nurses, pharmacists, pharmacy technicians and other healthcare professionals in times of disaster. This should also allow nurses to work in centralized locations to provide services, including remote patient monitoring across state lines.
- Allow license portability for non-physician providers for Medical Disability Exam vendors with the Veterans Administration (VA) in parity with what is allowed for providers who work within the VA health systems. Specifically, license portability is needed for Medical Disability Exam vendors for providers such as nurse practitioners, physician assistants, audiologists, psychologists, and more.
- Enable swift allowance of temporary visas for nurses, physicians, pharmacists, and healthcare professionals (especially those who have already completed clearances) to address need in times of disaster.
- Continue to encourage states to temporarily waive in-state nurse licensing and scope of practice requirements for the duration of the COVID-19 pandemic, allowing nurses to work in a centralized location to provide services, including remote patient monitoring across state lines.
- Direct the Department of Homeland Security to take the following actions to increase the supply of physicians during the national emergency:

    - Temporarily suspend the enforcement of the 2 year home residency requirement for any J-1 medical resident or fellow who is willing to work full time in a Health Professional Shortage Area (HPSA) or Medically Underserved Areas and Populations (MUA/Ps) or in a medical field that is directly treating COVID patients or assisting in the battle against COVID. This should not be restricted to just the Conrad 30 Waiver program. There are many other Interested Government Agency (IGA) Waivers including Appalachian Regional Commission (ARC), Delta Regional Authority (DRA) VA Waivers, and Health and Human Services (HHS) Waivers.
    - Temporarily make exempt from the annual H-1B cap any physician, or healthcare worker (as long as they are H-1B classifiable positions) involved in direct patient care who may be called upon to join the fight against COVID-19.
    - Temporarily extend the status and work authorization of any H-1B physician beyond the normal 6-year limit for the duration of the COVID-19 crisis or at least 1 year.
    - Require U.S. Citizenship and Immigration Services to reinstate premium processing for any H-1B filed for a physician, physician assistant, registered nurse, nurse practitioner, and any other critical healthcare professional for the purpose of fighting COVID-19.
    - Temporarily suspend the VisaScreen Certificate or equivalent requirement for healthcare professionals.
    - Temporarily grant current J-1 medical residents and fellows the ability to engage in COVID patient care even if that is not a part of their formal training program.
- Permanently expand waivers to permit pharmacists to diagnose and prescribe testing and treatment for COVID-19 and related influenza-like illnesses (in accordance with FDA approvals and treatment guidelines) in times of an emergency declaration. Additionally, recognize pharmacists as Medicare providers so that they may be reimbursed for these services.

Healthcare Coverage and Costs

- Provide federal premium subsidies for group continuation coverage (COBRA and state continuation that goes beyond COBRA) of at least 90 percent, preferably 100 percent, to people who lose health coverage because of COVID-19.
- Support temporary federal risk mitigation programs to support the financial stability of insurers and self-insured employers during the duration of COVID-19.
- Waive cost sharing for COVID-19, and COVID-19 mutations, testing, vaccine administration and treatment.
- Expand the payroll tax credit provided under the Coronavirus Aid Relief and Economic Security (CARES) Act for providing group health coverage for tax years 2020 and 2021, from 50 percent up to 100 percent of payroll taxes. Or, Congress should establish a direct grant program to fund employers that wish to continue their group health coverage during the pandemic.
- Establish a special enrollment period, allowing uninsured Americans to purchase coverage on the exchanges.
- Enhance the individual market tax credits (APTC) to reduce premiums for individuals, for individuals between 400 percent and 600 percent of the federal poverty level, because premium costs for those individuals often far exceeds 10 percent of income.
- Implement continuous eligibility for current Medicaid beneficiaries during the public health emergency.
- Provide additional FMAP, in line with National Association of Medicaid Directors' requested percentage, for states to address Medicaid program growth and high-acuity beneficiaries.
- Require CMS to compare MA plans 2020 Star Ratings and 2021 Star Ratings and use the higher scores to hold plans harmless due to data collection challenges during the crisis. In addition, CMS should provide plans having a 3.5 or 3 Star Ratings with the opportunity to earn a Quality Bonus Payment (QBP) for contract years 2022 and 2023 (2021 and 2022

Star Ratings) of at least 3.5 percent to improve program stability and the stability of benefit offerings for beneficiaries' given the COVID-19 public health emergency.

- While CMS recently provided additional guidance enabling Medicare Advantage organizations to submit diagnosis for risk adjustment payment from telehealth visits, plans need certainty that this policy will continue to be implemented moving forward. Therefore, Congress should codify that starting in 2020, CMS must adjust MA plan enrollee's risk scores to consider diagnosis data obtained through telehealth services covered by the plan.
- Bolster mental/behavioral health and social determinants of health support to address the COVID-19 ramifications.

Provider Support

- The CARES Act that included over $100 billion for providers is a welcome step, but it has proved insufficient for many providers. Congress must further support healthcare providers who are losing revenue during the COVID-19 pandemic and help them ramp back up efficiently when the system is ready to return to more normal business. While aid based on historic Medicare fee-for-service (FFS) payments may be the easiest and quickest way to provide support, as noted by CMS, it fails to meet all needs, including:
    - providers who have moved to value-based care, such as Medicare Advantage and other Medicare-sponsored value-based programs;
    - providers with a large Medicaid or other non-Medicare FFS population;
    - providers with a significant number of COVID-19 patients; and
    - providers located in rural areas serving a predominantly rural population.
- Help expand the public health infrastructure to support better bi-directional electronic information exchange between public health disease registries, labs, and electronic health records.
- Allow healthcare providers a 0% interest rate as part of the Accelerated and Advanced Payments provision under the CARES Act.
- Allow a temporary increase in Medicare and Medicaid disproportionate share (DSH) allotments during public health emergencies.
- Enable hospitals, health systems and other providers to be compensated for costs associated with remote patient monitoring, which otherwise meets evidence-based guidelines and appropriate patient data security and privacy standards, through direct federal funds that explicitly includes Registered Nurse-supported COVID-19 remote patient screening and monitoring solutions, creation of new reimbursement mechanisms, or a waiver of existing billing requirements.
- Provide additional financial support for in-home personal care attendants/caregivers.
- Provide support for mobile phlebotomy to eliminate delays in cancer diagnostic testing and mitigate risks associated with clinic and hospital visits for immune-compromised patients.
- Provide liability protections for healthcare providers should they be placed in a position of making resource allocation and treatment decision trade-offs.
- Provide immediate relief to teaching hospitals by temporarily doubling Indirect Medical Education (IME) payments.
- Extend by two years the Graduate Medical Education (GME) cap building period for new teaching hospitals that are currently within the five-year period that determines GME reimbursement caps.
- Impose a two-year moratorium on finalizing the Medicaid Fiscal Accountability Regulation (MFAR), as states and healthcare providers will not be able to implement the proposal during or in the aftermath of the pandemic or absorb the financial impact.
- Provide leniency and/or immunity under Occupational Safety and Health Administration (OSHA) rules for issues related to PPE shortages unless gross negligence can be proven.
- Provide essential support to the fitness center industry to ensure the continuation of employee and senior wellness programs. These programs provide invaluable services to millions of Americans during times of economic insecurity and uncertainty. Maintaining wellness program

access for seniors will promote health and well-being, preventing an escalation in long-term healthcare costs. There are multiple options for providing this support: inclusion of the fitness center industry in the SBA PPP program, providing business interruption insurance, offering lease relief, or creating a 9/11-style recovery fund.

Regulatory Relief

- Expand on CMS' allowance for Medicare Part B drugs to be administered in a home setting, in times of an emergency declaration if the patient and the patient's physician believe it is critical to help protect the patient's safety and health, by allowing the home administration supplier to be able to directly bill CMS for the items and services provided. However, we acknowledge that this additional flexibility may not be appropriate for oncology drugs unless HHS, working with the oncology community, deems it safe and appropriate.
- For those interventions that otherwise meet evidence-based guidelines and appropriate patient data security and privacy standards, waive strict application of remote patient monitoring coding requirements, such as the minimum time standards, which may limit providers' ability to use them and pose an undue documentation burden during the public health crisis.
- Grant a one-year extension of the implementation date of the CMS and ONC Interoperability and Information Blocking Final Rules to January 1, 2022 since the healthcare sector as a whole does not have time, personnel or funding to implement the rules during the pandemic.
- Amend Section 1135(b) of the Social Security Act by giving the Secretary authority to adjust benefits and administrative procedures for Medicare Advantage plans to match changes made in Medicare FFS.
- Amend Section 1135(b) of the Social Security Act to clarify the authority to waive certain HIPAA requirements for the duration of a public health emergency, rather than only for 72 hours.
- Enact the National Telehealth Strategy and Data Advancement Act (H.R. 5763) to ensure coordination of telehealth activities.
- Allow expansion of tools that can be used to determine disability (VASR-D) and that can be used as part of a mobile examination, particularly serving veterans in remote or medically underserved areas or in homeless communities, during this time of national emergency.
- Allow for partial completion of the Document-Based Questions (DBQs) when determining disability ratings through the Veterans Administration. DBQs that are only partially completed but meet the requirements of the VASR-D for rating of the claimed disability should be deemed sufficient for rating purposes and should not adversely affect the quality ratings of either the VA personnel utilizing the DBQs or the vendor completing and delivering the DBQ.

Innovation

- Enact the Developing an Innovative Strategy for Antimicrobial Resistant Microorganisms (DISARM) Act (H.R. 4100) to encourage innovation of new antibiotics to fight antimicrobial resistant (AMR) infections by providing additional reimbursement to hospitals that need to use these high-need antibiotics. These antibiotics incur significant cost to develop and while they are often the most appropriate therapy to treat AMR infections, the structure of the DRG mechanism creates a financial disincentive for their use. These drugs need to be made readily available and appropriately reimbursed for hospitals especially during the COVID-19 pandemic.
- Create public incentives to ensure private investment in improved vaccine technologies to address this and future pandemics.

As the committee moves forward on issues related to disaster preparedness, we stand ready to be a trusted resource that encompasses the perspective of all stakeholders in the private sector

committed to working in collaboration to be better prepared should another pandemic occur. Thank you for your efforts to gather information to ensure our country remains vigilant. HLC looks forward to continuing to collaborate with you on our shared priorities. Should you have any questions, please do not hesitate to contact Debbie Witchey at dwitchey@hlc.org or Tina Olson Grande at tgrande@hlc.org

Sincerely,

Mary R. Grealy
President