June 1, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: 42 CFR Parts 400, 405, 409, 410, 412, 414, 415, 417, 418, 421, 422, 423, 425, 440, 482 and 510 [CMS-1744-IFC], RIN 0938-AU31, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Attention: File Code CMS-1744-IFC

To Whom it May Concern:

The National Alliance of Safety-Net Hospitals (NASH), an association of private safety-net hospitals, wishes to submit formal comments on the interim final rule with comment period that the Centers for Medicare & Medicaid Services (CMS) published on April 6, 2020 to aid the nation's health care community in responding to the public health emergency (PHE) created by the novel coronavirus, COVID-19.

NASH appreciates the steps taken by CMS in this interim final rule and elsewhere in sub-regulatory guidance that have gone above and beyond to assist safety-net hospitals during this pandemic. The commonsense changes and waivers announced in this rule have offered the necessary flexibilities for providers not only to care for a surge of patients with COVID-19 but also to protect their staff and other patients from the virus.

We look forward to an opportunity when the PHE concludes to carefully examine the lessons learned from implementation of these changes and discuss with CMS which of these temporary changes should continue as a tool for innovation in the hospital community. With this letter we would like to highlight some of the actions taken by CMS in this rule that are especially beneficial for hospitals adjusting to patient needs during this crisis:

- Adding the patient's home as a permissible originating site for telehealth services.
- Revising the definition of "interactive telecommunications system" to permit telehealth patients to use devices that are familiar to the consumer, such as Skype or FaceTime.
- Maintaining facility and non-facility payment rates for distant site practitioners as if telehealth services had been provided in person in recognition that hospitals' costs for supporting the telehealth physicians have continued, if not increased, during the pandemic.

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- Relaxing direct supervision requirements to permit the virtual presence of a supervising physician, including a resident's teaching physician, through audio/video real-time communications technology.

- Offering flexibilities in the provision of inpatient rehabilitation services, including waiver of the "3-hour rule," removal of the post-admission physician evaluation requirement, and permission to complete physician face-to-face visits via telehealth.

NASH is glad to offer our support for the interim final rule and grateful for the opportunity to continue our partnership with CMS to give private safety-net hospitals the tools they need to care for the most vulnerable patients during this pandemic. We invite CMS questions about the views expressed in this letter and appreciate the agency's consideration of those views.

Sincerely,

Ellen Kugler, Esq.
Executive Director

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About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they serve patients who are more dependent on Medicare and Medicaid for health care; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.