COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, DC 20515

May 8, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Re: Requirements for a Safe Return to Comprehensive Healthcare in the COVID-19 Era

Dear Administrator Verma:

I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to exercise caution when it issues additional guidance for the safe return to non-emergent health care delivery in the coronavirus (COVID-19) era. This pandemic has already demonstrated the importance of public health preparedness and our system's gaps – and it is paramount that we be ahead of the curve as we responsibly reopen access to non-emergent care. If we allow elective procedures without putting in place essential safeguards, we could face significant surges in COVID-19 cases, leading to more hospitalizations, deaths, and unnecessary delays in economic recovery.

The Centers for Disease Control and Prevention (CDC) reported that, as of April 9, 2020, over 9,000 health care professionals had contracted COVID-19 and 27 of those workers had died as a result.[1] And the number of cases and deaths today among health care workers is certainly much higher.[2] Frontline health care staff have spent the last several weeks meeting an unprecedented need but must have the tools available to provide appropriate and safe care before they can further expand capacity. The stakes could not be higher. *Thus, I write to you at this critical time to urge you not to move forward with promoting the delivery of comprehensive health care services until your agency reinstates the recently waived patient and staff safety standards and frontline workers are assured the necessary personal protective equipment (PPE) and testing to be minimize risk.*

On March 18, 2020, CMS appropriately suggested that health care settings limit all non-essential medical care to devote hospital bed capacity, staffing, and PPE to the COVID-19 response. On April 19, 2020, CMS issued recommendations on "Reopening Facilities to Provide

1 https://www.nytimes.com/2020/04/14/health/coronavirus-health-care-workers.html
2 https://khn.org/news/true-toll-of-covid-19-on-u-s-health-care-workers-unknown/

Non-emergent Non-COVID-19 Healthcare." I am concerned that this directive gives too much flexibility to health systems, particularly in light of CMS having waived many Medicare rules related to patient safety during the COVID-19 pandemic. Elective services offered at this time would be provided with CMS's limited quality and patient safety oversight. It is unclear how CMS is currently monitoring the resumption of non-emergency care in the setting of extensive waivers or how CMS will respond and intervene if a resumption of non-emergency care results in a surge in cases or facility outbreaks. The answer to these questions is critical in ensuring that patients and staff are safe and protected during this unpredictable phase of the pandemic.

I am concerned that the April CMS guidance does not appropriately protect patients and staff. CMS's current guidance leads to a strong disincentive against expanding testing access and identification of cases in the community. Moreover, as you are well aware, our testing capacity remains extremely constrained, and, thus, we cannot be sure that many areas that appear to have low or relatively low and stable incidence of COVID-19 actually do without more testing. We are not close to the five million tests per day a bipartisan group of ethicists recommended before we can safely loosen current restrictions.[3] Screening by symptoms, as CMS recommended, is inadequate considering the high rate of asymptomatic patients.

Returning to non-emergency care without more directive guidance and oversight will put our vulnerable communities at the most risk of case resurgence and potentially worsen the disparities we are already starting to see. The evidence is clear that racial, ethnic, economic, geographic, and other disparities exist in rates of COVID-19 infection and mortality. Journalists are reporting that rural counties are seeing a delayed but concerning rise in cases.[4] Local demographic data has been released in some settings – and the trends are alarming. Without aggressive data tracking, analytic rigor, and resource mobilization, we will fail to control the pandemic and worsen the COVID-19 case burden in communities that are already marginalized.

While medical experts have proposed a number of more thorough criteria that we must meet prior to loosening restrictions on elective procedures, I want to specifically urge you to put staff safety and well-being at the forefront of any recommendations. In particular:

*Testing and screening of all incoming patients and testing of workers***.** To mitigate the risk of spreading the virus in health care facilities following a return to normalized operation, health care facilities must test all incoming patients. Symptomatic screening is insufficient and unsafe due to the high rate of asymptomatic infection. Patients seeking non-emergency procedures should be treated as presumptive-positive until testing indicates otherwise. Workers, likewise, should be routinely tested for their safety and the safety of patients. There must be strict oversight of this process and no institution should be allowed to resume normal operations until these measures have been documented and verified. This is critical for patient and staff protection.

*Resumption of Care Standards***.** CMS must address several provisions that were suspended through waivers over the past two months to address the anticipated COVID-19 surge. Hospitals must prove they can safely care for elective surgery patients and COVID-19 patients

[3] https://ethics.harvard.edu/files/center-for-ethics/files/roadmaptopandemicresilience_updated_4.20.20_0.pdf
[4] https://www.nytimes.com/interactive/2020/04/08/us/coronavirus-rural-america-cases.html

without resorting to a crisis standard of care. There must be enough staff to allow for the staffing patterns necessary in the COVID-19 units as well as to fully staff the other areas of the facility. Any change in schedule to accommodate an increase in capacity due to elective procedures must occur with the direct involvement of the staff. Accommodations must be in place to assure staff can travel to and park at work while maintaining social distancing.

Personal Protective Equipment. To return to elective procedures and admissions, there must be appropriate PPE available to all staff who come in contact with COVID-19 positive or suspected COVID-19 positive patients. If a facility cannot provide frontline staff with the appropriate PPE, then that facility is not prepared to resume elective procedures. A minimum stockpile of PPE at the current facility-specific burn rate must be on hand with the capacity to replenish as needed.

Workforce considerations. Frontline health care personnel have been in the eye of the storm, responding to this crisis for the past two months. A return to more normalized operations should be accompanied by the lifting of any monthly, quarterly, or year-to-year caps on vacation/earned time and the ability for staff to utilize sick time, vacation time, or other forms of paid time off (PTO). Employers should also provide paid sick leave for workers who must isolate, have symptoms, or who have contracted COVID-19 to prevent the spread of this illness.

Best practices for safety. CMS should encourage providers to collaborate with their clinicians and other staff to evaluate and make improvements to enhance safety for staff and patients and provide additional resources for providers to identify and adopt best practices.

Thank you for attention to this important matter. I look forward to working with you to ensure that our front-line health workers have all the tools they need to effectively target and mitigate the spread of this deadly virus. If you have further questions about this letter or the questions raised, please contact Amy Hall at Amy.Hall@mail.house.gov or 202-225-3625.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means