Kansas Hospital ASSOCIATION

March 27, 2020

Jackie Glaze
CMS Acting Director
Medicaid and CHIP Services
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Baltimore, MD 21244

Sent via email to Jackie.Glaze@cms.hhs.gov and to CMS Midwest Consortium Regional Offices at ROCHISC@cms.hhs.gov

RE: COVID-19 Waiver Requests - **KANSAS**

Introduction

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C.
1601 *et seq*.), and consistent with section 1135 of the Social Security Act (Act). On the same day, pursuant to section 1135 of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act to mitigate the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Daylight Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

States/territories can request approval that certain statutes and implementing regulations be waived by CMS, pursuant to section 1135 of the Act. The following list includes some of the temporary flexibilities available to CMS under section 1135 of the Act. Please check the box on the flexibilities that the state/territory is requesting. Please include any additional flexibilities that the

state/territory is requesting under the section 1135 waiver authority under "Number 6 – Other Section 1135 Waiver Flexibilities".

Please complete the following fields:

State/Territory Name: Kansas

Contact Name: Chad Austin, Executive Vice President, Kansas Hospital Association

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Date Submitted: March 27, 2020

1) **Medicaid Authorizations:**

- [X] Suspend Medicaid fee-for-service prior authorization requirements. Section 1135(b)(1)(C) allows for a waiver or modification of pre-approval requirements if prior authorization processes are outlined in detail in the State Plan for particular benefits
- [X] Require fee-for-service providers to extend pre-existing authorizations through which a beneficiary has previously received prior authorization through the termination of the emergency declaration

2) **Long Term Services and Supports**

- [X] Suspend pre-admission screening and annual resident review (PASRR) Level I and Level II Assessments for 30 days
- [ ] Extend minimum data set authorizations for nursing facility and skilled nursing facility (SNF) residents

3) **Fair Hearings**

- [X] Allow managed care enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeal first by permitting the state to modify the timeline for managed care plans to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements
- [X] Give enrollees more than 120 days (if a managed care appeal) or more than 90 days (if an eligibility for fee-for-service appeal) to request a state fair hearing by permitting

extensions of the deadline for filing those appeals by a set number of days (e.g., an additional 120 days)

4) Provider Enrollment

- ☐ Waive payment of application fee to temporarily enroll a provider
- ☐ Waive criminal background checks associated with temporarily enrolling providers
- ☐ Waive site visits to temporarily enroll a provider
- ☐ Permit providers located out-of-state/territory to provide care to an emergency State's Medicaid enrollee and be reimbursed for that service
- ☐ Streamline provider enrollment requirements when enrolling providers
- ☐ Postpone deadlines for revalidation of providers who are located in the state or otherwise directly impacted by the emergency
- ☐ Waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state
- ☐ Waive conditions of participation or conditions for coverage for existing providers for facilities for providing services in alternative settings, including using an unlicensed facility, if the provider's licensed facility has been evacuated

5) Reporting and Oversight

- ☐ Modify deadlines for OASIS and Minimum Data Set (MDS) assessments and transmission
- ☐ Suspend 2-week aide supervision requirement by a registered nurse for home health agencies
- ☐ Suspend supervision of hospice aides by a registered nurse every 14 days' requirement for hospice agencies

6) Other Section 1135 Waiver Flexibilities. Please include any additional flexibilities that the state/territory is requesting under the Section 1135 waiver authority:

A. **Expand the definition of appropriate transfer** (42 U.S.C. § 1395dd(c)(2)).

- This allows for the transfer of patients to a facility offering a lower level of care, so long as the accepting facility has the capacity and capability to treat the patient.

B. **Permit hospitals to deny transfers** unless the accepting facility offers a level of care needed by the patient that cannot be provided by the transferring hospital.

- These actions will help decrease the spread of the COVID virus.

C. Suspend the Condition of Participation Physical Environment requirements for alternate screening or patient care sites (42 C.F.R. § 482.41).

- This permits hospitals to convert areas not currently used for patient care to treatment areas, including screening and care to patients in their vehicles at drive-through testing sites and non-PPS hospitals to treat medical/surgical patients.

D. Allow Federally Qualified Health Centers and Rural Health Clinics to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings.

- This will allow flexibility in site of clinics to promote appropriate infection control.

E. Allow hospitals to disregard provisions in their medical staff bylaws relating to expiration of and granting of privileges (42 C.F.R. § 482.22).

- Granting hospitals flexibility to grant extensions to existing privileges and/or granting new privileges to new physicians absent full review and approval of the medical staff or governing body will ensure consistent staffing levels throughout the duration of this emergency.

F. Relax documentation requirements for transfers to post-acute care (42 C.F.R. § 482.43).

- Hospitals will need to efficiently discharge patients to post-acute care to free up needed bed space for incoming patients. The CoP includes numerous data sharing requirements that impede the ability to move patients into the next care setting.

G. Waive HIPAA privacy and security requirements (45 C.F.R. Part 164) beyond 72 hours and for the duration of the COVID crisis.

- This allows providers to focus on caring for patients.

H. Relax standards relating to protective equipment during sterile compounding (42 C.F.R. § 482.25).

- This would permit personnel engaged in sterile compounding to remove and retain face masks in the compounding area and allow re-donning and reuse throughout a single work shift.

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L. Waive sanctions under section 1877(g) of the Social Security Act (Stark Law restrictions on physician referral).

Including in this waiver should be the following provisions:

1. A waiver from requirements for written, signed provider agreements within 90 days.
2. A waiver from the requirement that regulates changes in physician compensation within the first year.
3. A waiver of the requirement that compensation be set in advance for services required as a result of the COVID-19 emergency.
4. A waiver from limitations on transferring patients to physician-owned facilities and expanding those facilities.
5. A waiver of restrictions on space, equipment leases, personal service arrangements: e.g. allowing physician practices to lease their employees, resources, etc. to a hospital to provide care during the public health emergency.
6. A waiver to allow health systems to utilize facilities that have physician ownership interests, such as dormitories, hotels, etc. to address health care needs during the public health crisis.
7. A waiver of Fair Market Value (FMV) requirements.

- This will allow hospitals to enter into temporary compensation arrangements that may otherwise violate Stark, engage in recruitment activities to ensure adequate coverage and allow for more efficient transition of patients to post-acute care. Including in this waiver should be the following provisions:

N. **Permit nursing students who are eligible to sit for the NCLEX exam the ability to practice nursing until they receive an NCLEX failure notice from the Kansas State Board of Nursing.**

- Kansas will graduate over 1,000 nursing students this year and with one testing site for Kansas located in a "hot spot" of the state, and the inability to take the NCLEX exam, we will need these nurses to assist with providing patient care.

O. **Waive the requirement that patients must meet the three midnight rule to qualify for transfer to a swing bed.**

- Transferring patients out of the acute care area will free up much needed beds.

P. Permit Critical Access Hospitals to be relieved from meeting scheduled payments associated with cost report settlements from prior fiscal years.

- This would a1llow flexibility for payments ahead of final settlements to alleviate cash flow concerns.

Q. Waivers for the following items related to telemedicine: Recognize that an originating site is anywhere the patient is located including rural health clinics;

1. Add inpatient hospitals as both originating and destination sites to monitor inpatients using telemedicine to reduce exposure and save PPE;
2. Clarify that reimbursement rates will follow current reimbursement levels consistent with visits performed in-person;
3. Verify that telemed video and telephone services are eligible for reimbursement consistent with Medicare rules;

4. Eliminate Medicare restrictions on licensing for telehealth;
5. Permit providers to treat patients without the requirement to establish a formal patient-provider relationship;
6. Eliminate Medicare restrictions on licensing for telemedicine. Allow billing using CPT codes 99444 and 98969 for new and established patients; and
7. Confirm Medicare screening without co-pays and deductibles do not violate the Civil Monetary Penalties Law or anti-kickback statutes.

- Allowing telemedicine reimbursement for these items will assist in reducing the spread of the COVID virus for patients and providers and maintain high quality patient care.

R. Flexibility for Teaching Hospitals. Allow flexibility for teaching physician presence with patients and medical residents.

- Medicare requires that a physician be physically present in the room/area to bill as the teaching physician. With hospitals running low on supplies they are limiting the number of providers with direct patient contact. If hospitals allow real-time audio video or access through a window for the teaching physician, or otherwise distance the interaction should be covered.

S. Waiver of certain behavioral health treatment requirements: to decrease patient exposure to the virus, provide patient care via telehealth and receive payment parity.

1. A waiver of certain seclusion rules for behavioral health patients to allow them to be isolated for treatment of COVID-19.
2. A waiver of any group therapy or in-person therapy requirements for behavioral health patients to allow for telehealth treatment, consistent with other telehealth waivers.
3. A waiver to allow providers to bill for behavioral health services normally requiring face-to-face treatment if the service is provided via telehealth.

- These measures will help to decrease patient exposure to the virus, provide patient care via telehealth and allow payment parity.

T. Waivers to allow the transfer of patients between facilities with shared or joint ownership even if they have different provider ID's: to provide needed bed capacity.

1. A waiver to permit transfer, instead of requiring discharge and readmission, between providers with shared or joint ownership even if they have different provider ID's.
2. A waiver of penalties for discharging patients early to lower acuity facilities. Current regulations require that hospitals formally discharge, get insurance/Medicare approval, and then re-admit patients to a new hospital, including a lower acuity facility. These facilities have available space and staff to care for patients and will facilitate additional capacity.
3. A waiver to allow patients to remain in any setting beyond the regulatory time (e.g. an ASC) for more than 23 hours.

- These measures will allow hospitals to address needed bed capacity in a manner that will allow them to limit the spread of the virus to uninfected patients.

U. Waive any penalties for Rural Health Clinics wishing to suspend certain services at select locations and provide services only to patients needing lab work, vaccinations and wellness exams.

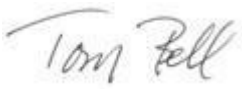
- Patients experiencing potential COVID symptoms would be redirected to another treatment site to decrease exposure to other patients and staff.

The expected duration of the waiver is March 1, 2020 (the effective date of the President's declaration under the National Emergencies Act) until the COVID-19 national public health emergency terminates.

We respectfully request that these waivers take effect immediately with a retroactive date of March 1, 2020. These measures will help Kansas have sufficient training, supplies, facilities and resources and will give health care facilities and providers much-needed flexibility by reducing administrative and regulatory burdens in order to facilitate Kansas's response to the COVID-19 outbreak and state of emergency. These measures are necessary to control the trajectory of COVID-19 in Kansas, and a blanket waiver of the foregoing federal requirements is appropriate to allow Kansas's hospitals and nursing facilities to properly focus their efforts on treating individuals with COVID-19 and curtailing the spread of the COVID-19 pandemic.

Thank you for your consideration of this request. If you have any questions, please do not hesitate to contact us.

Respectfully Submitted,



Tom Bell
President and CEO
Kansas Hospital Association