



March 27, 2020

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Sent via email to [Jackie.Glaze@cms.hhs.gov](mailto:Jackie.Glaze@cms.hhs.gov) and to CMS Midwest Consortium Regional Offices at [ROCHISC@cms.hhs.gov](mailto:ROCHISC@cms.hhs.gov)

RE: COVID-19 Waiver Requests - Kansas

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Secretary of the United States Department of Health and Human Services (HHS) declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his regular authorities, including temporarily waiving or modifying certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) requirements under section 1135 of the Social Security Act. This authority is intended to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area. The conditions of requesting a section 1135 waiver have been satisfied by President Trump's COVID-19 Emergency Declaration on March 13, 2020 and Secretary Azar's prior public health emergency declaration related to COVID-19 on January 31, 2020.

The Kansas Hospital Association, LeadingAge Kansas, Kansas Health Care Association and Kansas Adult Care Executives urge the Centers for Medicare and Medicaid Services to approve the attached waiver requests. 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. They 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,

Kansas Hospital Association



Tom Bell  
President and CEO

LeadingAge Kansas



Debra Zehr  
President and CEO

Kansas Health Care Association



Linda MowBray  
President and CEO

Kansas Adult Care Executives



Bill Tofflemire  
Executive Director

**Section 1135 Waiver COVID-19  
State/Territory Request Template**

**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:

<b>State/Territory Name:</b>	Kansas
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<b>Date Submitted:</b>	March 27, 2020

### 1) Medicaid Authorizations:

- 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
- 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

- 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

- 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
- 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. Suspend Section 1867 of the Social Security Act (the Emergency Medical Treatment and Labor Act, or EMTALA) for hospitals as well as on-campus and off-campus hospital-controlled alternate screening locations, regardless of whether they constitute dedicated emergency departments, in order to allow hospitals to direct patients to alternate screening locations and to screen or triage patients at a location offsite from the hospital's campus.
  - This will afford hospitals additional flexibility to triage patients and conduct medical screening examinations at on-campus and off-campus hospital-controlled sites while avoiding or limiting the spread of COVID-19 within hospitals.
  
- B. Waive EMTALA sanctions under Section 1867 of the Social Security Act for transfer of unstable patients and expand the definition of "appropriate transfer" under Section 1867(c) (2) and implementing regulations at 42 C.F.R. 489.24 to allow for the transfer of patients to a facility offering a lower level of care, so long as the facility has the capability to treat the patient, as necessitated by public health emergency.
  - This allows more flexibility to separate patients in order to prevent the spread of COVID-19 and to preserve resources at facilities with specialized capabilities and capacity to treat the most acute patient needs without risking an EMTALA violation.
  
- C. Waive Section 1814 of the Social Security Act and implementing regulations at 42 C.F.R. 483.30 to allow physicians to delegate tasks to non-employed and employed physician assistants and advanced practice registered nurses including physician visits required for initial assessments, certifications, recertifications and other required or medically necessary physician visits.
  - Due to the strain on medical personnel, allowing physician assistants and advanced practice registered nurses to perform these functions will allow physicians to focus on those with urgent medical needs.
  
- D. Waive discharge planning requirements to allow hospitals to discharge patients who no longer need acute care to post-acute providers that can accept them in an efficient manner to free beds for acutely ill patients. See 42 C.F.R. 482.43(a) (8); 485.642(a) (8).
  - This allows patients to be discharged and self-quarantined more quickly and preserves acute care resources to treat patients who require treatment in higher-acuity settings.
  
- E. Allow hospitals to treat medical/surgical patients in non-prospective payment system hospitals (e.g. long-term care, health clinics and psychiatric hospitals) and/or other units (e.g. rehabilitation). This would ensure that psychiatric hospitals, health clinics or rehab units can be utilized for acute care, and that acute care is paid as acute care.

- This allows hospitals flexibility to use their space more efficiently, including setting up quarantine facilities and areas for known cases of COVID-19, which can be important for controlling and preventing the spread of infectious disease.
- F. Waive the physical environment conditions of participation at 42 C.F.R. 482.41 and requirements of participation at 42 C.F.R. 483.90 to allow providers to receive payments for services provided to affected beneficiaries in alternative physical settings, such as mobile testing sites, temporary shelters or other care facilities, including but not limited to, commandeered hotels, other places of temporary residence, and other facilities that are suitable for use as places of temporary residence or medical facilities as necessary for quarantining, isolating or treating individuals who test positive for COVID-19 or who have had a high-risk exposure and are thought to be in the incubation period or to expand overall capacity to meet high demand.
- This ensures that hospitals and nursing facilities can designate alternate sites for patient care without violating physical environment requirements and would allow for appropriate quarantine, isolation and recovery facilities.
- G. Waive sanctions under section 1877(a) of the Social Security Act (relating to limitations on physician referral).
- For the duration of the outbreak, this removes a liability concern for referring patients to the closest or most appropriate care setting.
- H. Pursuant to Section 1135(b)(7) of the Social Security Act, waive sanctions and penalties arising from noncompliance with the following provisions of the HIPAA privacy regulations: (a) the requirements to obtain a patient’s agreement to speak with family members or friends or to honor a patient’s request to opt out of the facility directory (as set forth in 45 C.F.R. 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. 164.520); and (c) the patient’s right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. 164.522).
- Suspending these portions of HIPAA contemplates an influx of patients and provides the flexibility needed to share information about infection and treat patients more efficiently.
- I. Waive limitations under Section 1851(i) of the Social Security Act on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers.
- This removes the complication of Medicare Advantage network participation to ensure full payment to out-of-network providers while responding to COVID-19.
- J. Waive Sections 1814(a) and 1835(a) of the Social Security Act, and enacting regulations at 42 C.F.R. 484.60 and 42 C.F.R. 484.55(a), to (a) relax physician requirements related to ordering and certifying home health services; (b) allow non-physician practitioners, such as advanced practice registered nurses and physician assistants, to develop plans of care; (c) permit home health agencies to temporarily perform initial assessments and determine patients’ homebound status

remotely or by record review; (d) relax written signature requirements and written documents when those can be accomplished electronically; and (e) relax the homebound requirement for patients quarantined or isolating in their home for a minimum of 14 days, or who are otherwise high risk and unable to leave their home due to COVID-19. These patients should be presumed to be homebound and in need of skilled intermittent care.

- These waivers promote efficiency and prevent vulnerable patients from coming into contact with individuals with COVID-19. Due to the strain on medical personnel, allowing non-physician practitioners to perform these functions will allow physicians to focus on those with urgent medical needs. Relaxing homebound requirements will also allow patients to be discharged more quickly and preserves acute care resources to treat patients who require treatment in higher-acuity settings.

K. Permit basic evaluation and treatment to occur in patient vehicles, assuming patient safety and comfort. See physical environment requirements at 42 C.F.R. 482.41; A-0700 et seq.

- This will help prevent potential spread of COVID-19 to hospital facilities.

L. Waive enforcement of patient rights related to care planning, choice of attending physician, activities, personal privacy, confidentiality, order for seclusion, patient visitation rights and immediate access to records. See 42 C.F.R. 482.13 and 42 C.F.R. 483.10.

- This is necessary because hospitals and nursing facilities may be required to undertake public emergency responses to prevent spread of COVID-19 that makes compliance with those conditions of participation and requirements of participation impossible.

M. Allow verbal orders to be used more than “infrequently” (read-back verification is done) and authentication may occur later than 48 hours. See 42 C.F.R. 482.24, A-0407, A-0454, A-0457.

- This will allow for more efficient treatment of patients in a surge situation.

N. Allow ICU patients whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs be reported later than close of business next business day, provided any death where restraints may have contributed is continued to be reported within standard time limits. See 42 C.F.R. 482.13(g), A-0214.

- This is necessary because hospital reporting may be delayed due to increased care demands. Eliminating penalties keeps the focus on urgent patient care.

O. Waive requirements at 42 U.S.C. 1396a (a) (57), (w); 42 U.S.C. 1395cc (a) (1) (Q), (f); and 42 C.F.R. 489.102 that requires hospitals, nursing facilities, home health and hospice to provide information about advance directive policies to patients upon admission.

- Allowing flexibility in meeting these requirements will allow staff to more efficiently deliver care to a larger number of patients. This would not apply to the requirement for hospitals, nursing facilities, home health and hospice to inquire about the presence of an advance directive.



- P. Waive the HIPAA security requirements for video communication in a telehealth visit at C.F.R. 164.312(e) (1).
- While CMS has lifted many of the patient site requirements to allow telehealth in the home, as well as non-rural areas, many facilities are not prepared with secure platforms that they own and control which are also accessible to the patient. The request is to allow providers to use readily available platforms like FaceTime, Whatsapp, Skype, etc. to facilitate the telehealth visit with the patient at home.
- Q. Waive the following screening requirements under 135(b)(1)(A) and (B) so the state may provisionally, temporarily, enroll providers: Disclosures and disclosure statements – 42 C.F.R. 455.104
- This will allow an expedited process for providers to enroll in Medicaid and Medicare to ensure access to health care providers
- R. A waiver of the restrictions within 42 CFR 435.1103 in order to allow hospitals and long-term care facilities to provide presumptive eligibility.
- By waiving or waiving pre-approval requirements, providers can deliver the necessary care without waiting on pre-approval. Additionally, this would allow a nursing facility to accept residents who meet medical criteria, and provide services and receive payment without waiting for approval of a Medicaid application.
- S. Waive requirements around testing and certification of nurse aides (CNAs) in Kansas, including (a) allowing CNA certification written exams to be administered online through designated organizations; (b) waive in-person skills component of CNA exam; (c) waive the 120 day requirement from date of hire as a nurse aide to being added to the registry; (d) allow nurse aides who have lapsed their active status on the nurse aide registry to be automatically reinstated, as long as they were in good standing before the lapse; (e) allow current nursing students who have completed at least one clinical rotation to be eligible for hire as a CNA. These candidates will not require state testing or registry status; and (f) allow flexibility in CNA course instructor qualifications. See 42 C.F.R. 438.152(a) (5), 42 C.F.R. 438.154; 42 C.F.R. 483.156.
- This will allow more certified nurse aides to enter the workforce at a time when the long term care workforce shortage is greatly exacerbated by COVID-19 emergency situation.
- T. Waive 42 CFR 483.70(f)(2) and 482.23(b) in order to allow persons who have completed degree or certification program applicable to their position (including nursing, rehab therapist, social work, activities and food/nutrition services) but not yet licensed, certified or registered, to work in nursing facilities and hospitals. Allow those who are qualified to take the NKLEX and are unable to do so to carry out nursing duties.
- This will allow greater access to potential workers at a time when the long term care workforce shortage and nursing shortage is greatly exacerbated by COVID-19 emergency situation.

- U. Support provider capacity to meet resident care needs by waiving nursing facility training and in-service requirements found in 42 C.F.R. 483.35(d), 42 C.F.R. 483.95, and waiving minimum staffing for registered nurses at 42 C.F.R. 483.35(b).
  - In this time of national public health emergency, nursing home providers are facing a growing staffing crisis. As resident care needs grow and efforts to prevent and mitigate the spread of the virus intensify, staff members across disciplines and job types continue to be quarantined due to exposure or symptoms, fall ill, or are required to stay home to provide child care as schools close or care for ill or frail loved ones. Providers need relief from certain requirements and flexibility to ensure they are able to use every available resource to meet residents' needs in this critical time.