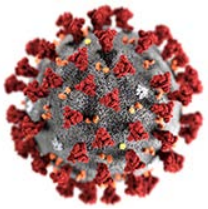
COVID-19 Statewide Hospital Huddle Summary Tuesday, March 2, 2021



Chad Austin expressed his appreciation for everyone joining the call. There are a number of positive developments with the continued decline in hospitalizations across the state related to COVID-19 along with the recent approval of the J & J vaccine. More vaccine is on its way to Kansas, so we can get more vaccines in arms. We know that many of our hospitals are continuing to work closely with their local health departments and other community partners related to vaccine distribution as well as other COVID-related items. We are pleased to have Dr. Marci Nielsen from the governor's office join us today to talk about some of the COVID-19 activities and vaccine activities that we are seeing across the state. We are also pleased there have been some developments related to the Rural Emergency Hospital legislation that we have been working on for so many years. You may recall that Congress passed that demonstration program at the end of December. Now the Kansas legislature is following suit by putting that model program in statute. Yesterday, we saw that the Kansas Senate did debate on the floor the REH legislation. They moved it to final action where it will be worked on today. That is great news as it pertains to that legislation.

Statistics Relative to COVID and Dashboard Update - Sally Othmer
(Slides attached to the daily COVID-19 email 3-2-21)
We continue to report hospital TeleTracking data pulled from HHS Protect. Since the spike in November and December, the number of hospitalized COVID-19 patients has been on the decline. This graph goes back to mid-July, when reporting to TeleTracking became mandatory. The percent of hospitals reporting represents the level of reporting on the most current day reported on the graph. All six regions demonstrated a drop in the number of new cases from the week prior. It is important to note that the number of tests administered has dropped as well. The bottom graph displays weekly new statewide cases and deaths. All of the data from these graphs are pulled from information posted on the KDHE website. Weekly deaths are based on the cumulative number published by KDHE every Monday, Wednesday and Friday. The "Statewide COVID-19 Deaths by Date of Death" graph from the KDHE site displays daily numbers. The daily numbers on the graph rise as the death records are reviewed. So the totals for February do not yet match the totals displayed for February on the KHA weekly graph, but they will catch up. Updates to TeleTracking and some vaccine resources are available at the KHA website. https://www.kha-net.org/. The KHA COVID Dashboard has changed over time, and we will continue to be updated to report information in the best way possible. Please reach out to Sally Othmer, sothmer@kha-net.org with questions or recommendations.

COVID-19 Preparedness and Response Update – Ron Marshall
As previously mentioned on a hospital huddle call the state has a large supply of Abbott BinaxNow rapid antigen tests for COVID-19. This test produces a result in about 15 minutes. The state is making these tests available to hospitals, LTC facilities, health departments, schools and others that have a CLIA certificates at no cost. The Abbott tests can be ordered through your County Emergency Manager. Because there is such a large supply of these tests the kits being provided may have a very short outdate. In some situations, only 2-3 weeks. We have been working with the Kansas Health and Environment Laboratory and Boston Consulting Group on several related issues.

1. There is confusion in the requesting process regarding the order quantity. Hospitals that were trying to order a box of 40 tests have in some cases received 640 tests because of confusion of a "kit" of 40 tests versus a "box" of 16 kits containing 40 per kit. With the short outdate receiving 640 tests will likely create wasting tests that cannot be used prior to outdating. I believe as of this morning KDHE and KDEM will be addressing and clarifying the order quantity.
2. A question came up this morning as well as to if hospitals would find value in using these rapid antigen tests to screen staff prior to reporting to their work assignment. This would be in addition to the CMS Focused Infection Control requirements that all staff be screened prior to reporting to their work assignment. I am guessing most hospitals may not be interested in additional resources required to do antigen testing on staff prior to work, however if I am wrong and anyone is interested, please contact me.

3. We have not been able to confirm if hospitals may use these tests obtained through the State for performing tests on anyone other than staff, i.e. patient testing. Once we are able to get an answer we will share that information. Just one word of caution, if anyone is receiving these tests from the State (free of charge), you are not allowed to charge for such testing.

Updates on COVID-19 Response, Vaccinations, Data, etc. – Marci Nielsen, PhD, MPH
(Slides attached to the daily COVID-19 email 3-2-21)
Marci Nielsen, Chief Advisor to Governor Kelly, expressed her appreciation for having her on the call. Several years ago, some of you may remember when I worked at the Kansas Health Policy Authority. I have always been very grateful for all the support that Kansas hospitals and, in particular, the KHA has provided to the state over the years. Certainly, nothing like this pandemic was ever something we could have planned for. But the support that KHA is providing to the state is really unparalleled. Thank you! Please note on the front page of this Provider Manual, it states, Version 2 – March 1, 2021. I wanted to call out that we have several changes and clarifications that we have made in our Provider Manual. For those of you who haven't ever seen out Provider Manual, it is really just the Bible for what we are trying to do in Kansas in terms of distributing the vaccine. I'm going to point you to a couple of slides, but before that, I'm just going to step back for a second and provide you with some bigger picture information about what is happening this week as it regards vaccine and vaccine distribution. Then we will hop in to some of the more granular details outlined in the Provider Manual.

Vaccine Distribution – five big topics for you:

1. Many of you are aware that there are big increases in vaccine allocations for Kansas this week. And that is terrific news for our state. We are receiving more than 23,000 doses of the Johnson and Johnson vaccine which was over the weekend approved for emergency use authorization. Fantastic news. It will ultimately be a game changer to have a third vaccine added to the market. We are expecting that two more vaccines that are in the pipeline. I think it is going to change the dialog, and in Kansas, we will be sharing that vaccine with local health departments much like we have sent Moderna and Pfizer vaccine to local health departments. We will be talking about that more when we have the vaccine in the Provider Manual.
2. Secondly, we are now sharing race and ethnicity data on vaccinations on our dashboard. That information, as you might imagine, does not paint a positive picture in terms of minority populations having vaccination rates equivalent with majority populations. So we are going to need to focus on communities of color in a more specific way. You will be hearing more about that this week at the end of the week. And you have to have now heard the good news about vaccinating teachers. We are going to be targeting some specific communities to ensure that the race and ethnicity data that is now being shared can tell a more positive story. More news on that front to come.
3. You have, and I'm grateful for it, you have been all involved in helping the state on the data reporting fixes in administration of vaccine. That work is in motion. There are daily snapshots that you all are sharing for those of you who are enrolled providers. This aggregated view of the data is going to help us figure out which elements of HL7 and WebIZ EHRs are problematic in terms of sharing data. I thank you for your assistance in helping the state. We definitely want to get these issues addressed.
4. We are expecting to be finished with vaccinating teachers in the very near future. We will complete the first doses by the end of next week and then the second doses will be complete by the week of March 22. This is tremendous news. Many of the local health departments had already been prioritizing teachers, but this will allow us to across the state feel confident that teachers and school staff will be vaccinated. It will certainly be important as we move to reopen schools to in-person learning.
5. The final data point I want to underscore on this call, you may have been hearing that there are some disparities between urban and rural counties' access to vaccine. That has largely been as a result of how Pfizer vaccine is prioritized for urban counties. It has been requiring ultra-cold storage and has much bigger packaging requirements than Moderna, with almost 1,200 vials in a package. What we have found the last few weeks is we have been receiving fewer packages of the Pfizer, which has meant that urban counties has been receiving less vaccine per capita than the less populated counties who have only been receiving Moderna. That is going to be addressed in part as the federal retain pharmacy program, which began about 3 weeks ago will be sending Pfizer vaccine to many of the Kansas urban areas. You may have also heard that KDHE is now looking at every county to determine how much vaccine they have been receiving per capital and ensuring that we are sending to those

counties that have been receiving the least amount of vaccine per capita and then clarifying that the state is vaccinating Phase 2 population only. Of course, counties have flexibility within each phase, but we won't be sending vaccine to those counties that are ready to move to Phase 3. Instead, we will be trying to get vaccine to those counties that are still vaccinating Phase 2 populations.

Those are the five big target areas. The increases in vaccine allocation for Kansas, new race and ethnicity data available, our data reporting fixes are absolutely in motion. We will be vaccinating teachers this week. Prime doses will be done. Booster doses by the third week in March. We are making adjustments per capita on per capita allocations to ensure equity between urban and rural counties.

Vaccine Provider Manual – Slide 2 points toward the table of contents. In blue, you see several references to updated information. I would encourage you to get familiar with this Provider Manual. As I mentioned, it's kind of the Bible of how vaccine distribution is working in Kansas. Go to those pages where you will see updates, so you can get a sense of what has changed. Slide 9 shows an overview of the vaccine distribution process. There is a little star at the box where you see the word "hospitals." Those stars are meant to underscore any changes or updates that we are including in the slides. Here, while the federal government manages the delivery of vaccines, the state governments are responsible for determining the distribution. Slide 10 shows the updates, and you will note that some of the exclamation points are just to provide more clarity on some of the timing around when the shipments are ordered and when we receive them. In particular, I would like to move to slide 15. This is a change that folks need to be aware of. What we want to clarify is some of the processes and procedures for when Kansas as a state government is providing guidelines that we would like the local public health departments to follow. You'll see here, we have updated the slides about the guidelines. You'll see there is a length to the phasing guidelines. Slide 16 shows managing the excess vaccine supply. I want to point you to the redistribution box at the bottom. I know one of the things that hospitals in particular have been struggling with is transferring vaccine to other providers. I would point you to the redistribution process so that everybody is aware that prior to redistributing vaccine, there is an agreement that needs to be on file with KDHE. Every time a vaccine is transferred to another provider, a transfer form is required to be filed. And a temperature tracking log will be important for you to report what the temperature is every hour while the vaccine is in transport. These are the kinds of clarifications. I am going to stop the Provider Manual viewing and head back to the beginning of the Provider Manual. There is a lot of information in this document. Lots of clarifications as we have learned throughout this process the information that either wasn't clear, or the information wasn't complete.

Updates on COVID-19 Vaccines – Karen Braman
(Slides attached to the daily COVID-19 email 3-2-21)
With the approval of Johnson & Johnson's COVID vaccine over the weekend and with three vaccines now approved for emergency use, summary information was provided regarding each vaccine and factors to keep in mind in terms of storage, transport, dosing and administration, and efficacy that might be helpful as questions are received from staff, patients, boards or community members.

While the most significant difference with J & J's vaccine is that it is a single dose and is stable refrigerated for up to 30 months; there are other variables to keep in mind as more vaccines are approved and as staff are potentially dealing with multiple different COVID vaccines on a regular basis. The dose of the J & J and Moderna vaccines is 0.5mL, while the Pfizer dose is 0.3mL. From a logistics and storage standpoint, the J & J vaccine in cartons of 50 doses, may be easier to manage for small vaccine dose orders, while the Moderna minimum order is 100 doses and Pfizer's tray contains 1,170 doses.

Pfizer received approval from the FDA for two labeling changes recently: the first change approved several weeks ago clearly indicates that each multi-dose vial contains six doses. The latest change last week was to allow for the Pfizer vaccine to be stored at regular freezer temperatures for up to two weeks. The language from the new labeling regarding frozen storage was provided. It does indicate that the vaccine could be returned to the ultra-frozen state one time after being held at standard frozen temperatures. That said, the more variables there are to manage with each vaccine, let alone many vaccines, the more confusing the information can be and the increased importance of vigilance with respect to each separate vaccine's requirements.

A few other factors to note where there are differences across the vaccines are in age and vaccine efficacy. Moderna and J & J's vaccines approved for ages 18 and above; and Pfizer's currently approved for age 16 and above. Moderna and Pfizer are currently studying their vaccines in ages 12 and above. J & J has indicated that their studies will include pediatrics, including infants. All manufacturers are conducting additional testing in pregnancy as well.

While J & J's vaccine has different vaccine efficacy than Pfizer and Moderna, it's important to note that all 3 vaccines are highly effective, they all used different vaccine efficacy endpoints, and the J & J vaccine trial continued after Pfizer & Moderna's Phase 3 had concluded and variants were more prevalent in several regions where it was tested. When the US data is isolated from overall data, J & J's vaccine is 72 percent effective in preventing moderate to severe/critical COVID; and when severe/critical cases are stratified, it was almost 86 percent effective against severe disease and 100 percent effective at preventing hospitalizations and death.

On the horizon – each manufacturer is testing boosters, with Pfizer and Moderna testing the effectiveness of a three-dose regimen in extending immunogenicity; and J & J testing a two-dose regimen. All manufacturers also have variant-specific boosters in the works. Lastly, we anticipate Astra Zeneca's and Novovax's vaccines coming before the FDA for EUA review in the coming months. The J & J vaccine information has been added to KHA's webpage, which offers one page including COVID-19 vaccine information and information for all EUA-approved vaccines.

The CDC has updated guidance regarding vaccine administration fees, and reminds providers that no vaccine recipient may experience any cost-sharing for the vaccine. Private insurers, Medicare, Medicaid and HRSA's uninsured program may be billed for vaccine administration. The specific guidance was provided, along with links to HRSA and CMS resources for additional information.

Finance and Reimbursement Update – Jason Barb, BKD

PRF Reporting Portal – No updates have been listed on the reporting portal website. There is still no ability to enter data in the portal. The current understanding is that providers will have a minimum of 30 days to report from the date portal opens. We are anticipating the due date being in the beginning part of April.

PRF Funds – There were several FAQ's updated on Feb. 24, 2021:

- There is a new FAQ regarding the RHC Testing Program under the Auditing and Reporting Requirements section clarifies that there is a separate reporting portal for RHC at www.rhccovidreporting.com. It is fairly limited in the information needs to be inputted there, but that is one of the exceptions. Pretty much everything else is going to be reported on the main reporting portal that is not open. The RHC and there is a separate one for nursing home infection control. Everything else will be consolidated. Those two items are separate.
- There are a couple of new items under the use of funds section. I don't think either of these are necessarily new from discussions we have, but there are new FAQs. One specifically is looking for guidance on restrictions on use of PRF funds for hospitals that receive Medicaid DSH payments. Essentially the response to that effectively indicates that if the DSH funds are used to cover uncompensated care costs, those same costs cannot be claimed from PRF funds. It essentially came down to another FAQ dealing with double dipping type items.
- Can entities claim time spent by staff and director-level folks on COVID-specific matters such as task forces or preparing responses to COVID-19. The response indicates that yes, to the extent that those salaries are specific to COVID-19 responses, they can be claimed provided that they are not already reimbursed or obligated to be reimbursed from other sources. Again, I think this is fairly consistent with what we have discussed in the past. However, there is some more clarified guidance on that.
- The final one is not a new one, but a modified one. It deals with cost reimbursement related to PRF payment. This is of particular importance to CAHs. Items paid under cost cannot be reimbursed with PRF funds. Incremental costs that are not cost reimbursed would be eligible. Those costs that are claimed will not be offset on the cost report, which potentially will result in more cost reimbursement than would have otherwise been received. That will have to be taken into consideration when you make your final claims for what you will utilize from the PRF funds. That's going to be very entity-level specific, so I would definitely encourage all of you to reach out to those who prepare your cost reports to discuss and see how that specifically will impact you.

PPP Loans – We have been seeing a large number of those, especially those that are under the $2 million mark that have been receiving the forgiveness letter. Just a reminder that those funds can be audited for a period of 6 years from the

data of loan forgiveness or payments are made. You need to retain documentation to support that for six years in the event that SBA comes to audit that.

Sequestration – It is scheduled to resume April 1, 2021, so your payments will go down a little bit on the Medicare side. The CARES Act suspended sequestration from May 1 to Dec. 31, 2020. The Consolidated Appropriations Act extended suspension to March 31, 2021.

Medicare Accelerated Payments – If you participated in that, recoupment is scheduled to begin one year from the date your received those funds. So likely to see that happen beginning in April as well. Many received advances in mid-April 2020. Under current law, recoupment begins one year from date accelerated payment was issued. For the first 11 months, recoupment will be at 25 percent of Medicare payments.

State and Federal Advocacy Update – Audrey Dunkel/Landon Fulmer/Tara Mays
Federal Update – As you all know, the reconciliation bill has passed the House. It has a variety of interesting provisions related to additional funding for vaccine and testing, some expansions on health care coverage related to Medicaid. It would allow extension of Medicaid and SHIP as well as some sweeteners to get states that haven't expanded Medicaid to do so by increasing their FMAP for two years for the regular Medicaid program. The net on that for Kansas between the estimated cost of expansion and the additional money over that two-year period is about $250 million dollars or so, according to the Kaiser Family Foundation. There are some changes in the health insurance marketplace subsidies. There is also some language about the temporary increase to the Medicaid DSH financing. In order to address the impact of the temporary increase in FMAP on the state DSH contributions. There is a requirement that CMS recalculate the annual DSH allotments from the year the temporary COVID-19 FMAP-related increase applies just to level-set things there. There are also some additional monies for mental health and substance use, some rural health grants and then some additional changes in the PPP program allowing 501(c)3 organizations that don't employ more than 500 employees per physical location to be eligible for the program. That may be of interest to some.

Now the conversation switches over to the Senate. There are some things that were not included in the discussions. One was the minimum wage increase to $15 an hour. There is probably still some discussion on to make that happen, but I know many of our people were concerned. The Senate is probably going to be taking it up tomorrow. They are going to be going through an open amendment process, so there are going to be a lot of votes and a lot of amendments. One of those will definitely be on additional funding for the Provider Relief Fund. That received no funding in the House bill. That is likely to pass in the Senate. So that will be part of the discussion going forward. It passed in the first round of setting at the table for this bill by a vote of 99-1, so I assume that will pass this time as well. But they are going to have figure out a way to offset it. But I fully anticipate, though, that that will happen. As Audrey said, the minimum wage has been declared non-germane by the parliamentarian in the Senate. That basically means that it is not going to happen. There was some talk about using tax laws in order to include some kind of minimum wage threshold encouragement to companies that were not paying minimum wage, but that is more or less off the table. I just don't think it has the votes in the Senate to pass.

State Update – There is a lot going on at the statehouse ahead of the turnaround deadline. That deadline requires that all bills that are non-exempt bills be passed their chamber of origin. Among those things that have been passed that we have been working on as Chad mentioned earlier, the Rural Emergency Hospital bill. Senate Bill 175 were debated on the Senate floor and is up for a final action vote currently in the State Senate. Good news there. That bill is likely able to be discussed past the turnaround deadline.

The Legislature is taking up right now and is in the throes of deciding what will happen with the Kansas Emergency Management Act and whether that will extend the state emergency declaration that has currently been issued by Governor Laura Kelly. The Senate has the position in SB 273 that they passed on the Senate floor yesterday that creates a new committee to review disaster orders among other things. It also requires some oversight and review by the Attorney General's Office and places some limitations on how that review happens when they are in session and when they are out of session. On the House side, HB 2416 also deals with the Kansas EMA and dealing with how they might look to structure that. That bill passed out of committee yesterday and is expected to be debated on the House floor in the coming days. It is important to note that how those bills turn out will affect whether the disaster emergency management piece gets extended. We are following that closely and preparing some legislation, so should that bill be

held up in the process and the state declaration gets extended, we will have some protection for our Kansas hospitals. We continue to work on that and follow it very closely.

One other thing we have been working on, the Provider Assessment language is in the House and the Senate budget proposal, which ensures that providers will remain whole until the CMS on the federal level has approved those changes. We are excited to be able to tell you that.

I wanted to update you that the governor's Medicaid expansion proposal that includes medical marijuana paid for that has been introduced in both the House and the Senate in the committees, so those will be exempt bills. I'm not sure that they will be worked or have a hearing at this point, but they have been introduced. We continue to work on telehealth with the insurance providers.

The legislature will take a couple of days off Monday and Tuesday of next week and then they will be back to work bills for the next couple of week before the first adjournment and April break.

Member Questions – Cindy Samuelson
Q1: *Regarding essential workers working on the retail side. Can you provide an estimated date on when they will be offered the vaccine? Many communities are in still in Phase 2, but what you are saying is they might have prioritized by age or by different sections of Phase 2, so each county may have a different date when they start getting to those grocery store workers?*
A1: Dr. Marci Nielsen – Yes and no. You'll recall that the state has the guidance on the phases. Each of the counties are putting in place their priority populations based on their own community. So if retail workers happen to be in Phase 2. I am familiar with meat packers being in Phase 2 along with grocery store workers. I can't speak to retail workers. I know that is very frustrating for folks in a given community when a specific population has been prioritized. Of course, this is because of the vaccine shortage. It is so important that we have this influx of vaccine coming from J&J, but also from the national pharmacy partnership program returning doses to Kansas. The shortage is the rate-limiting factor, and I can't stress enough the importance of folks trying to remain patient and understanding of the circumstance we find ourselves in. More and more vaccine is coming onto the market, and that will make a huge different. The best advice to the hospital is to reach out to your county health department folks to find out how they are walking through each phase and see if they have an estimated date.

Q2: *As you are looking at future allocations to coming Kansas, does the state have an estimated timeline for moving to Phase 3?*
A2: Dr. Marci Nielsen – You will see if you look at the guidance online, we have March kind of loosely listed. It is really hard to say if we will be able to move to Phase 3 in March. We are sticking with that current projection for the time being, but a lot depends on supplies from the federal government.

Q3: *For the 30 counties where vaccination have been suspended, is there a plan on how this will work moving forward in regards to receiving vaccine every other week? This county still has people in Phase 2 category that needs to be vaccinated.*
A3: Dr. Marci Nielsen – Just a reminder that it is not that the program is suspended. They are just moving to every other week of vaccine allocation. We will continue to keep close track of the per capita rate that every county is getting to ensure as much equity as possible. Also, to be able to target those specific kinds of more crucial population that are at the highest risk of illness and death.

Q4: *If a hospital has zero vaccine, do they still need to complete the daily snapshot?*
A4: Dr. Marci Nielsen – If they have zero vaccine, and they don't intend to get any more vaccine, my understanding is that they have already shared the cumulative numbers. Per KDHE's Phil Griffin (during our 2-16-21 Hospital Huddle) - it would only be the initial completion of the daily snapshot survey that will account for the cumulative previous vaccine that the hospital had. When it shows a zero inventory, they would not be expected to go back in every day and enter zero. Hospitals will need to fill it out the first time, but if they have no inventory, they will not need to continue.

Q5: *Using PRF funds for COVID-related personal expenses, is that subject to the $100,000 salary limitation?*

A5: Jason Barb – I believe it would be. That particular FAQ does not specifically address that particular situation, but pretty much anywhere else where there is discussion of wages, it does wind up being capped at that particular rate.

Q6: *Can you provide a little more information about the state's plan to expand the distribution of the vaccine to other vaccination providers such as hospitals, especially providers with high throughput capacity?*
A6: Dr. Marci Nielsen – That is going to be really important, particularly as we move into Phase 3. We want to be able to engage not only hospitals with high throughput. But we also want to be able to engage the physician community certainly because we will be adding populations of individuals who have severe illness. We want those individuals to be thinking carefully with their physicians and providers about the appropriateness of vaccination. The details you will see we intend, and I should double check my dates here. That footprint expansion is going to be critically important. You will start to learn more about the state plan next week. We are still putting together some of the final pieces. I think folks can continue to expect that we will use local health departments as kind of a framework. But we definitely want to build additional providers on to that as more supply comes in to the state.

Q7: *What about WebIZ? Will you provide an update on the WebIZ issues and the steps KDHE is taking to resolve the technical side, such as the fixes for HL7, for example?*
A7: Dr. Marci Nielsen – Stepping back for a minute, I think hosptials in particular understand the interoperability challenges we have on the HIT front and how they have created some technical difficulties as we are trying to share information between immunization registries via HL7 with EHRs and then with the CDC. We had hoped that we would be able to figure out where the data lag and glitches were most problematic and fix them by working with our vendor. It became clear as we learned more and more working with individual providers that every provider was having a nuanced different struggle. So we moved, as has other states like Texas, New York and Pennsylvania to kind of a work around. Fixing WebIZ and all of these data capability issues have to be part of our long-term plan. In the short term, we want to make sure that we are reporting accurately the number of vaccines that are being administered. So the daily snapshot, which is that aggregated view, together with the flat files for providers who we know are having WebIZ reporting issues, that is the short-term fix. We expect that will help us in the diagnosis for the longer-term problems with WebIZ. Of course, this was the first week that we are receiving the daily snapshots, so it is premature for me to say what we have learned from that process. But by the end of this week, we hope to have some insights. I can tell you we have lots and lots of folks focused on this and trying to fix this. The appreciation that we have for the provider community's understanding and their willingness to work on this is immense.

Q8: *I know you know that this is now four different reporting systems hospitals are having to have this additional burden to put data into. I know there is data fatigue, and you know that as well. Do you have any idea how much longer hospitals are going to be required to report in the new state survey?*
A8: Dr. Marci Nielsen – I truly do not. We are trying to work through this as quickly as we can. I just don't have a line of sight yet into what we are learning. I think most folks are aware that we are working with some consultants as well as with the vendor. This is the top priority to get this fixed. At this point, the federal government is not limiting the amount of vaccine that is coming to Kansas despite what appears to be our low administration rate. But that is really an important factor that is kind of prioritizing this issue from an administrative perspective above all else. The last thing we want to have happen is Kansas get less vaccine because of data lag. It really is at the top of our list.

Q9: *How would the pending legislation at the state level affect certain public health orders and mask mandates*?
A9: Audrey – That is complex. If the emergency declaration is allowed to expire on March 31, 2021, that means that any executive orders and flexibilities that have been part of that would go away. However, what is happening is those two separate pieces in the House and Senate on the emergency management act changes and sets up a different framework for putting together all of those executive orders and defining what should be a local only decision. It engages legislators in making some of the emergency management decisions. So the truth is until they hammer out all of the details and finalize something, it is not terribly clear except that they do have some sort of plan that engages the legislature more in the decision-making process as far as emergencies go. Not a great answer, but it is the best one we've got.

Next KHA COVID-19 Hospital Huddle

Hospital Huddles will occur on the first and third Tuesdays of each month. Our next Hospital Huddle will be **at 10:00 a.m.** on **Tuesday, March 16.** Email Cindy Samuelson if you have guest speakers you would like to have present on an upcoming Hospital Huddle.