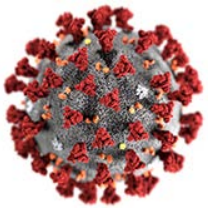
COVID-19 Statewide Hospital Huddle Summary Tuesday, April 20, 2021



Chad Austin welcomed everyone to the Hospital Huddle. He expressed his hope that everyone is doing well, despite the fact that everyone is experiencing snow on April 20. KHA had our virtual Spring District Meetings last week. We covered several topics, including the latest on the advocacy activities on the federal and state level. Also gathered some feedback on workforce issues during the COVID-19 pandemic as well as how hospitals have been of approaching the price transparency requirements that were put in place at the beginning of 2021. If you were not able to attend one of the District Meetings last week, we have a recording available for members. As for COVID-19 and today's huddle, there has been a lot of activity going on related to vaccine. Today we are pleased to have a guest speaker, Dr. Tim Williamson who is the Physician Vice-President of Quality and Safety, The University of Kansas Health System. Dr. Williamson is going to share some insight on vaccine and variants as well as vaccine hesitancy. We appreciate his taking time out of his schedule to join us today. If there is anything that we can help you with as you are dealing with issues in your local community, please don't hesitate to reach out to us, whether it's COVID-related or not. We appreciate the opportunity to serve you and your colleagues in your communities. If you have any questions, just let us know.

COVID-19 Vaccine – Karen Braman

We want to make sure everyone is aware that the FDA revoked the emergency use authorization of Eli Lilly's monoclonal antibody, bamlanivimab, when used alone. That is due to the emerging data on the increase of variants' resistance to the bamlanivimab when used alone. It does not impact Lilly's combination of product or Regeneron. If providers do have BAM on site, you may order estesivimab to be used along with it. We included this information as well as the link to Amerisource direct order site in our Daily Update yesterday.

With the pause of the J&J vaccine just one week ago today and the review by the CDC Advisory Committee on Immunization Practices regarding the rare clotting events, we felt like this would be a good opportunity to discuss those updates related to J&J vaccine and COVID vaccine in general. We also will discuss the importance of addressing vaccine hesitancy. I am pleased to introduce Dr. Williamson to help us sort through all of this information. As Chad mentioned, he is a Physician Vice-President of Quality and Safety at The University of Kansas Health System. In addition to that, he is an associate professor in medicine, and he is a specialist in pulmonary critical care. I have also had the pleasure of working with Dr. Williamson on COVID-19 vaccine related issues since last fall. He also has been a speaker on our COVID-19 Clinical Calls. We appreciate Dr. Williamson sharing his expertise this morning.

COVID-19 Variants, Vaccines and Vaccine Hesitancy – Tim Williamson, MD, FCCP

Tim Williamson, MD, FCCP, Physician Vice-President of Quality and Safety, The University of Kansas Health System thanked KHA for the opportunity to be on the call. He is a pulmonologist by training. He grew up in western Kansas in Garden City, the former home of the world's largest free outdoor concrete municipal swimming pool, which is of course closed. I have been in the eastern half of the state since college. We are going to spend most of our time talking about J&J, and I know a lot of folks follow the vaccine development closely. I have had the pleasure of working with KHA and KDHE on vaccines. We were reminded yesterday that we started those calls in September. It is amazing how time flies.

As mentioned of Johnson & Johnson, there was a pause on the usage and distribution of their vaccine a week ago today. Kind of setting the background for why that happened. Most of you are probably familiar that there are maybe a half dozen different vaccine monitoring safety mechanisms that are primarily passive, meaning

that they don't actively survey patients for problems. They rely on providers such as physicians, nurses, patients themselves, etc. to enter adverse events related to or associated with vaccine. Towards the end of the week prior to the vaccine being put on pause, one of those particular systems called VAERS (Vaccine Adverse Event Reporting System), which is one of the primary systems in place, started to note a signal of clotting that we will talk about in more detail. Out of an abundance of caution, it was recommended that a pause would be appropriate.

Those events were somewhat unusual. They were six episodes of what is called Cerebral Venous Sinus Thrombosis, or very specific blood clots in the brain. Those happened in women ages 18-48, with an average age of 33. There have been about 7.2 million doses of J&J given, and so that worked out to be roughly .8 something per one million. Less than 1 per million associated events. These clots were unusual in that they were also associated with Thrombocytopenia platelets. Some of those as slow as 10,000 to 12,000. Some more like 120,000, but fairly low platelets. In those patients, there was to my knowledge one death. A couple were in the ICU. There were not a lot of comorbidities, although 3 were obese. Three of them had associated intracranial hemorrhages. Three others had other clotting such as DVT, PE, etc. Of those, there was an additional one patient in the Johnson and Johnson clinical trial. That patient actually was male. All the others were female that I just mentioned. That patient was 25 years old and male and had a similar presentation. CDC's Advisory Committee on Immunization Practices (ACIP) met on Wednesday of last week to review the data that was known and to make recommendations. They have asked for more data and a little more time. Then they meet again this coming Friday for four hours to review the additional data that has been requested and make some recommendations to what happens moving forward.

I think it is really important to understand that there is a background rate of CVST. This is not a benign condition. It can cause death and can cause stroke and other swelling. But there is a background rate of this. We use Dr. Kevin Alt, who is from our faculty who is part of the ACIP. He used this on Friday morning's media update. If you missed that, please check it out. It was a really good update on what is going on with J&J. But there is somewhere between, in the general population, 3-15 per million per year. We know that the associated risks will increase with COVID-19, so actually getting the disease. A huge increase, maybe as much as 60 times the background rate. Pregnancy it is something that is seen. Pregnancy is substantially higher than the background rate. So that would be somewhere around 100 per million. Oral contraceptives have an increased risk. When you look at somewhere around 6 or 7 per 7 million, that is roughly one in a million. That in and of itself is lower than the background risk. Part of what we may be seeing is overall background risk. That being said, typically CVST is not associated with Thrombocytopenia. This is a different phenomenon and partly why that needs to be sorted out. So the mechanism clots were also seen with AstraZeneca. Those were more prominent. I don't have all of that data, but they were more prominent and were beyond just CVST.

Both of these J&J and AstraZeneca are what are called adenovirus vectors. The goal is always to create antibodies to the spike protein so less of Sars Covid-2 can get to the cell. J&J and AstraZeneca, they use adenoviruses. J&J is a human one; AstraZeneca is a chimpanzee one to basically wrap DNA that imposed the recipe to make the spike proteins. It is taken up by the cells basically to produce a protein that is expressed. This mechanism is different from the Moderna and Pfizer. It appears that particularly in mutated in the Thrombocytopenia. It may be immune-mediated. I think a new term has been coined, vaccine immune Thrombocytopenia and clots. So there are a couple of things. From a global perspective, ACIP is wanting to know and why they are using this week to understand is what are the true numerator and true denominator. By that I mean, are there additional patients who have had this? This was all presented within 1-2 weeks of receiving J&J vaccine. So the additional week's pause should allow the majority of these if they are going to present themselves from the vaccine that has already been given should allow that to manifest itself and get a true sense of the number. They are also scouring all the databases and looking for any additional cases of these. The other thing is to understand the true denominator. While 7.2 million or so of these vaccines have been given, only about 1.5 million have been given to women between the ages of 20 and 50. That data, for

reasons I don't understand doesn't include Texas. They like to do their own things sometimes. So what's the true number? If that is one in a million of all vaccinations, that may be somewhat different than if that number is substantially higher when adjusted for women ages 20-50. So they are going to further understand that. Interestingly, the same technology was used for Ebola and other vaccines that were given using this technology and there was no probiotic events noted in those vaccines. People have asked about Pfizer and Moderna. Of the 98 million doses of Pfizer given, there have been no thrombotic events that have been reported. Of the 85 million Moderna, there have been three thrombotic effects, all with normal platelet counts. Really, not have been noticed with any substantial significance in those groups. Basically, they will come back on Friday and have recommendations for the FDA that I think will be likely followed. Dr. Fauci earlier this week said that he believes it will be soon. But I think many of us think it will be soon but with many maybe some recommendations or restrictions in terms of patient populations to avoid or use other vaccines if available. I think we will have to wait and see what they say. My guess is that they will resume with restrictions. Short term that has not impacted Kansas a whole lot, because we were getting fairly low doses. I think we got 45,000 of J&J one week. We were then targeted to get around 15,000 a week. But it is an important tool in that it is one dose and easier to store and would be much easier to give either in ERs or clinician offices. I think what is really important from a clinician standpoint to make sure clinicians understand particularly for ED docs, but also neurologists or hospitalists or critical care. But I think ED is where many of these patients would present and may not be necessarily included in some of the normal alert bulletins. Particularly thrombosis or signs or symptoms: headache, nausea, neurologic changes, but also back pain or leg pain, and signs and symptoms of PE. They should avoid the use of heparin until they have had a chance to test for platelet antibodies with the same assay that is used for heparin. To use non-heparin for treatment. That needs to be part of the history is the vaccine in the past, 1 to 2 and maybe 3 weeks.

I still think that this is a safe vaccine that may have some restrictions around it. But there is no doubt about it, and I'm sure you all have seen it as well, the impacts on what was already vaccine hesitancy. We are already seeing across the state administration sites that are declining additional allocation because of the slow uptake on vaccine. We here in Kansas City are having trouble filling our vaccination appointments, and this has not helped. I have had several patients ask, "Now that we have all these clots with J&J, maybe they are all not safe. I think we all on this call have a very important role in promoting the safety and efficacy of these vaccines and talk through some of the things that these are less than the background rate and the very real risks that COVID still provides. I think the biggest impact of the KDHE and others have worked on advertising, which is great. We definitely need to reach some underserved areas and populations, and that's great. But I think one of the biggest impacts is that one-on-one physician conversation. I have not been 100% convincing patients, but I have probably been 80% in terms of being able to talk through some of their concerns. This all comes in the setting that we know that the variants are here. Hong Kong is a very dominant strain. We are seeing it in Michigan that it's impacting younger patients. We see in our own census overall, our census is skewed younger than maybe it had been previously in the hospital. There is still, at least for the Hong Kong variant a decent coverage with the vaccine. But it also underscores the need that we can't let down the mitigation efforts. Cases are flat or rising, and that's with decreased amount of testing across the state and across the country. You all have probably seen in your own communities, and we've seen certainly around here, people didn't get the memo that COVID isn't over. The pillars of infection control in terms of not staying distanced, not crowing, not wearing masks has dropped off dramatically. We don't know the impact of that loosening of restrictions of behavior. Of things like spring break and Easter. We have graduations coming up. We have plateaued, but by no means is COVID over. I do feel like we are on that continual race of getting people vaccinated. I worry about the behavioral changes.

One of the common questions is one boosters. Pfizer's CEO had made a comment that we would likely need a booster. We expect that from the vaccines that immunity will wane over time. We are only 8 or 9 months out from the first trial participants. We know that the MRNA vaccines still have good antibodies at six months, but we don't know what that means at nine months or a year. Antibodies wane, but that doesn't mean that your

immunity is completely gone. There are other immune memory functions that help protect you so partly we will have to know over time in terms of reinfections or breakthrough infections in patients who have been vaccinated. I think we all expect that at minimum, there will likely be a yearly booster. I think we should all be planning for that in our healthcare facilities. What does that look like to giving a booster and for patients? Now, what that looks like, is it the same drug, is it the same amount of drug, can you cross over between Moderna and Pfizer vaccine or any vaccine. There are a gazillion unanswered questions that will come along. But I think at minimum, we have to be prepared. Yes, there will be boosters. Hopefully not less than a year, but at minimum, most of us will probably see a yearly phenomenon much like the influenza vaccine. We can talk about influenza if we have time. We have potential to have a little rougher influenza year. Basically, influenza didn't appear this last year. This coming year, the overall influence of activity may be hard to was low enough that it may be hard to guess what strains to put in the vaccine as well as we see a lot of the infection prevention pillars that were in place this past year slipping rapidly. I think it's going to be a rougher influenza year.

Finally, as we just talk about a couple of major steps in terms of getting vaccines in arms. One of them is to decentralize. There have been a lot work on mass vaccination clinics. We are nearing the end of their efficacy. I know we are hoping to transition in May some time and start getting that more de-centralized. But there is still a lot of constraints around storage, administration, wastage, documentation, etc. that have to be navigated. So that's why if we can get back the J&J vaccine, that will be important. But we are working through how we start de-centralizing that and getting it into at least some of our bigger clinics. I think going to places of business, going to large businesses or factories will be helpful. Knowing, though that there may be an impact on workforce depletion if everyone comes down with side effects at the same time. So maybe stagger that. My sincere hope is that we can get past state boundaries and that can just vaccinate people and create it more like the flu shot rather than trying to figure out where you live and where you work.

Member Questions on Vaccines – Cindy Samuelson

Q1: *Is there any information to indicate if ACIP will recommend limiting the J&J to only those over a certain age or a limit based on gender?*

A1: Dr. Williamson – I think it is very possible. When you look at the options that are on the table, and you listen to them talk, I think it is likely that there will be recommendations. Of course, it is challenging to stray from those recommendations. My guess is that it will be some limitations or recommendations around age and gender, particularly women ages 20-50, if I were trying to guess. They have not said anything final, so that is really just me trying to read the tea leaves.

Q2: *Do you think this will delay review or approval of the* AstraZeneca *vaccine?*

A2: Dr. Williamson – That's a great question. I personally think that AstraZeneca has uphill battles. If I were a betting man, I would not be surprised if they don't get their EUA because of kind of the rocky things they have had from what little I've seen, their thrombosis stat is higher. And, particularly if J&J resumes, there will be three available vaccines. We're not meeting the uptake on those. If I were to guess, ACIP will be very cautious about recommending and the FDA will be very cautious about a EUA for AstraZeneca. I think this is a good example of the system working the way it should. I think the down side, of course, is that it added to the vaccine hesitancy among patients. But they have been looking for any signals. The moment there was once, they jumped on it. It ended up not being anything, but I think AstraZeneca is going to struggle a bit to get their EUA.

Q3: Will the boosters be targeted to a variant, the original strain, or can they be targeted toward both*?*

A3: Dr. Williamson – I think that falls into the bucket of the gazillion things we don't know. With the MRNA vaccines, they have the ability very quickly and nimbly, maybe in a couple of weeks or less to adjust for variants. I would, again, if I were going to try to predict the future, I would guess that the boosters or at least the MRNA vaccines would be adjusted to include additional variants.

Q4: *If you had to identify the single biggest reason for vaccine hesitancy, what do you think that is?*
A4: Dr. Williamson – It's hard to pick one. This is always a bit of a third rail, but there is data that it follows some political lines, which I think is unfortunate. This should never be political. It should be about health and science. I think there is still a lot of misinformation and general lack of trust in terms of the hesitancy. It think the one, if I were to sum it up would be misinformation. It's really hard to undo misinformation.

Q5: *What are your thoughts on COVID overshadowing or stifling influenza virus the past year? Do you think there is any proof of that happening?*
A5: Dr. Williamson – My personal take on it is that it shows that the pillars of infection control work. We didn't have people coming to work sick. People were wearing masks. They were staying home. They were not congregating in groups. All the things that were done to help prevent COVID were especially effective for influenza, which doesn't have some of the challenges that Sars CoV-2 did. Influenza doesn't spread asymptomatically, like Sars CoV-2 did. And it is not as contagious. It is not nearly what COVID was. All of those pillars of infection control, I think worked. We didn't see influenza, and it was not because we were not testing for it. We were, and we didn't see it. I would love for some of those infection prevention pillars to continue on through flu season. I'm likely to wear a mask next flu season when I'm going to be out. I wouldn't be surprised to see some shifts by some people to continue some of those pillars of infection control. I think that is what happened. We were still looking for it, but it wasn't out there.

Statistics Relative to COVID and Dashboard Update – Sally Othmer
The hospital data from TeleTracking has shown a bit of an upward trend in COVID-related hospitalizations recently. Since TeleTracking reporting became mandatory in mid-July, we hit the highest number of hospitalizations reported at 1,629. The lowest was on March 31, 2021 at 227 and this week we are up to 256. The numbers of new cases remain relatively low but have shown increases lately after a sharp decrease through February and March.

As cases drop and vaccinations rise, I am hoping to move the dashboard to a focus on vaccine administration. The state data for these graphs come from KDHE and the national stats come from the CDC website. They display the number of first dose, second dose and the percentage of the state and national population. Kansas appears to be on the same track as the US overall. As a reminder, these percentages are for based on the entire population, which is not entirely eligible for the vaccine, but provides a nice comparative.

KDHE recently added new vaccine related data to the site, highlighting the Social Vulnerability Index, providing breakouts by Race and Ethnicity as well. KHA will expand the dashboard to a regional perspective of vaccine administration in the days to come.

HHS is planning a webinar for this Thursday, April 22 at 1:00 CT – *"serve to let people know that we are looking at the data path forward to make things more sustainable and give an opportunity to share feedback.''*
Register in advance for this webinar:
https://www.zoomgov.com/webinar/register/WN_m_pHgd3hQ9OGcH4pU0VGcg. After registering, you will receive a confirmation email containing information about joining the webinar.

Updates to TeleTracking and some vaccine resources are available here and at the KHA website. The KHA COVID Dashboard has changed over time and 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 – Ron Marshall

Updated Guidance for Emergency Preparedness – CMS recently updated their Guidance for Emergency Preparedness, known as Appendix Z, State Operations Manual. This is also known as the Emergency Preparedness Conditions of Participation. Appendix Z was first developed in 2016 from the lessons learned from Ebola. So on March 26 of this year, the lessons learned from the current pandemic of COVID has been incorporated into what is called the CMS QSO-21-15-All. I've also included the links to the website where you can find that. Appendix Z applies to basically 17 provider types. The ones that are probably of most interest are hospitals, CAHs. There is a difference between the requirements for hospitals and CAHs, RHCs, long-term care, etc. It is actually pretty easy to read. All the changes are in red. I have included a couple examples of those changes. It really focuses the latest version on emerging infectious diseases. I don't think it would be any surprise that CMS would expect any emergency plans that are updated or developed include provisions for emerging infectious diseases. The plan should also include planning for things that we experienced with COVID, such as: shortage of PPE, transportation of patients to get to a higher level of care. Those are a couple of changes. It also talked about planning and drilling including emerging infectious disease, working with state and community partners on the planning efforts and drills and exercises.

CMS Focused Infection Control Survey Tool for Acute and Continuing Care – Although this has been out since first published on April 30, 2020, CMS focused infection control survey control survey tool for acute and continuing care. This was updated on Dec. 30, 2020, and is also known as CMS QSO-21-08-NLTC. It still remains in effect. We are receiving, and I understand, a number of calls of people who are all tired of wearing a mask and doing social distancing, etc. It is important to let everybody know that until CMS issues a new memo that CMS and KDHE expect the masking and screening to be in effect for all health care facilities. Again, the survey tool has changes in red from April 30. One of the big changes was self-reporting of the presence or absence of a fever by staff. It added the nose, mouth and eye protection. Also, when you use disinfectant, they need to be EPA registered. With the declining number of cases, or previously declining number of cases, although as Sally says, the number of cases are starting to go back up. A number of hospitals have reached out to ask if they still need to wear masks and if they still need to keep screening. The answer is yes at this point in time. We have reached out to KDHE Health Facilities to inquire if they have heard anything from CMS about any potential changes. Personally, I don't think it is likely with these variants in place. What is happening in Michigan, New Jersey and other states where the cases are really spiking. I personally believe that hospitals need to set an example by wearing masks and making sure we follow what Dr. Williamson referred to as the pillars of infection control. We are reaching out and we know that checking for the presence or absence of a fever is really not a reliable indicator of a COVID-19 infection. We will be asking that question as well and will keep everybody informed as we hear an answer from either KDHE or CMS.

FDA EUA at Home COVID-19 Testing – The FDA has issued a number of emergency use authorization for a home COVID-19 testing kit. It listed a number of them that has been recently approved for at-home testing. The Ellume test, which is an antigen test takes less than 20 minutes. By June 1, these should be available at pharmacies nationwide. These will be over-the-counter and will not require a prescription. The Abbott BinaxNow test, which I think most people are familiar with, because KDHE has had a very large supply and have been providing them free of charge to hospitals, schools, clinics, nursing homes, etc. It is again an antigen test and produces results in less than 15 minutes. And it is actually packaged about $24 for a package of two. They recommend that it be done serially, so two tests. It should be available at CVS, Walmart and Walgreens pharmacies. It is approved for adults over 15 and actually down to two years' old with adult supervision when the swabbing is performed. The LabCorp Pixel test, which is really not an at-home test, but doesn't require a physician's order is a PCR test. So you do the swab at home and send it to LabCorp. You can get these swab kits at Walgreens. It takes 1-2 days. It is really expensive for $120, but it is available. And, of course, CVS has many clinics, about 1100 nationwide. They can do an antibody test that takes about an hour. One word of caution is, I have reached out to KDHE, and they are saying that CDC and KDHE guidance is that the antibody test is not a diagnostic test. So if you are trying to lessen quarantine because you have been exposed, they will

not accept the antibody test being positive to get you out of quarantine any sooner. So those are available, and of course, are available without a physician's order, the Go Get Tested sites are still available where you can get tested for free in Kansas. It will probably require a longer turnaround time.

Finance and Reimbursement Updates – Jason Barb, BKD

PRF reporting portal – No updates are listed on the portal website, so there is still no ability to enter data in the portal. It is our current understanding is providers will have a minimum of 30 days to report from date portal opens.

PRF FAQs – Latest updates were posted on March 31, 2021. There is nothing new since the last hospital huddle. You can view the FAQs at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/provider-relief-fund-general-info/index.html.

Sequestration – At the last call, the moratorium on sequestration was up in the air. It has actually now passed. There will be no sequestration through December 31, 2021, and no action is needed. That will be automatic.

Medicare Accelerated Payments – Recoupment has begun. As a reminder, recoupment begins one year from date accelerated payment was issued. For the first 11 months, recoupment will be at 25% of Medicare payments. It is not exactly coming out to 25%, due to the way the formula is computed on those, but it is pretty close. So if you are getting remits and seeing payment be a little bit less than what you would normally expect, that is likely why. You should see some reporting codes on there indicating that withholding.

Provider based RHC caps – Provider based Rural Health Clinic caps were Included in the Consolidated Appropriations Act signed into law December 27, 2020. Hospitals should have received rate letters for new rates effective April 1, 2021. It is likely to be based on rate in effect as of December 31, 2020 plus 1.4% inflation rate. Double check your rate letters to make sure those were correct. Grandfathered clinics will receive lesser of the actual cost or 2020 AIR plus inflation.

State and Federal COVID-19 Advocacy Update – Audrey Dunkel/Landon Fulmer/Tara Mays

Federal – On April 13, the House passed the Senate's version of the Medicare Sequester Moratorium Bill. It includes the RHC fix. The bill increases sequester in 2030, but we haven't yet seen what that will cost.

We continue to look for Phase II of the President's Infrastructure plan, for what we have been calling it the Care Economy Bill. We are watching for more details for the President's budget as well, to see what kinds of investment there will be in health care going forward. As we've talked, there are some things procedurally that have come up. All of you are probably familiar with the fact that the American Rescue Plan passed by a legislative process called reconciliation. That requires only a majority vote in the Senate, not a super-majority vote like most bills that pass that change the substance of the law. Basically, these bills will change the spending and taxing categories within a fiscal year budget. So once the budget is passed, you can change it by a simple majority vote. Since Democrats have a very bare majority in the Senate and a pretty small majority in the House, they have chosen to use this for the American Rescue Plan. The big news over the past couple of weeks, is the Senate parliamentarian has ruled that you can do another one of those in this budget year. So it looks like the leadership in both the House and Senate will likely have an opportunity to both the infrastructure bill and the Care Economy Bill by reconciliation. Before this, there was worry that they may not be able to do both. But it looks like they will be able to do both by reconciliation. The parliamentarian basically ruled that you can do two reconciliation bills within a fiscal budget year. In theory they could do another bill for FY2021, which they are in. After they pass the 2022 budget, then they could fix that budget with the reconciliation bill. That's really the big news that those things are lining up to make for, in addition to the

actual budget itself, a pretty busy year on various health care matters as we go forward into the summer and into the fall.

State – The Kansas Legislature adjourned for what is known as first adjournment on April 9, they will return to complete their work during veto session starting May 3 and anticipate going through May 11. They have tentatively slated sine die for May 26. The budget committees will begin meeting ahead of their return during the week of April 26.

Overview of items that have passed

HB 2208, the mega health bill includes establishing certification and funding for certified community behavioral health clinics, enacting the rural emergency hospital designation, enacting the rural hospital innovation grant fund, authorizing telemedicine waivers for out-of-state healthcare providers, reducing certain requirements for the behavioral sciences regulatory board and expanding out-of-state temporary permits to practice behavioral sciences professions. The bill passed the House on a vote of 120-2; the senate on a vote of 34-4 and was enrolled and presented to the Governor on Friday, April 16.

Unemployment reform passed in House Bill 2196. Passed the House on a vote of 122-0 and the Senate on 38-0 and was presented to the Governor late last week. Among other changes to the Kansas Department of Labor system it also Employer protections and payment certification are covered in the legislation. The bill requires employers be held harmless and not owe any amount to the State for fraudulent or improperly paid claims. The bill requires DOL to make immediate restitution to employers without requiring a hearing or request from the employer.

Base budget bill passed in House Bill 2007; was assembled after nine round of negotiations between members of the House and Senate conference committees. Among a list of items, The Legislature agreed to add language directing the Kansas Department for Aging and Disability Services to make expenditures to lift the moratorium on admission at any of the state hospitals and direct the agency to make no expenditures which impose a moratorium on admissions at any state hospital. The committee tied the provisions to an agreed-upon date of October 1, 2021, to ensure expectations of compliance are met. House Bill 2007 passed the Senate on a vote of 21-14 and the House on a vote of 70-53.

Utility Costs Loan Deposit Program contained in Senate Bill 86 creates a new three-year loan program providing incentives for the making of loans to eligible borrowers for the winter weather event of February 2021. The legislation benefits wholesale natural gas consumers. The conference committee report passed both the House 117-6 and the Senate of 36-2 and is with the Governor.

Outstanding Items

There are a few outstanding items that they will take up when they return, including any vetoed items, omnibus bill, and outstanding conference committee reports. 340B was brought up in the appropriations and is likely to be brought up when they return. Final CCR on healthcare stabilization fund, The bill increases the required minimum liability insurance requirements to levels currently purchased by 94 percent of providers and was agreed to in conference and is likely to be taken up when they return. The Attorney General's Opioid Litigation Fund which enacts the Kansas fights addiction act to establish a grant program for the purpose of preventing, reducing, treating and mitigating the effects of substance abuse and addiction will be in House Bill 2079 as agreed to in the conference committee.

Member Questions

Q6: *Is CMS still requiring facilities to record visitor temperatures?*
A6: Ron – No, there is no requirement to record a temperature, and actually we discourage recording anyone's actual temperature, particularly staff. If you record temperatures of staff, that triggers some additional OSHA recordkeeping requirements.

Q7: Is there still a requirement to take the temperature, but not record it?
A7: Ron – What it says is you have to ask about the absence or presence of a fever. It can be self-reported. You do not have to document anything, but you have to make sure that what is in your policy is actually, what you are doing. If a surveyor asks, you must prove that your policy and practice shows that you are asking about a fever in any contractor, volunteer or staff.

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, May 4.** Email Cindy Samuelson if you have guest speakers you would like to have present on an upcoming Hospital Huddle.