State of Utah

GARY R HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health
Executive Director's Office

Joseph K. Miner, M.D., M.S.P.H., F.A.C.P.M.
Executive Director

Marc E. Babitz, M.D.
Deputy Director

Nate Checketts
Deputy Director
Director, Medicaid and Health Financing

April 3, 2020

Jackie Glaze
Acting Director
Medicaid and CHIP Operations Group Center
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBJECT: UTAH-REQUEST FOR SECTION 1135 WAIVER FLEXIBILITIES TO ADDRESS COVID 19

Dear Ms. Glaze

On March 6, 2020, Utah Governor Herbert declared a state of emergency for the State of Utah due to the COVID-19 Pandemic. Therefore, the State of Utah hereby requests that the Centers for Medicare and Medicaid Services (CMS) grant waivers of certain federal healthcare statutes and implementing regulations pursuant to Section 1135 of the Social Security Act.

To date, CMS has issued numerous blanket waivers that are applicable to health care providers that furnish items and services in good faith, allowing for reimbursement and exemption from sanctions for noncompliance due to the COVID-19 pandemic. On March 23, 2020, CMS also issued a blanket waiver of certain provisions applicable to health care providers in the state of Utah, pursuant to a request by the Utah Hospital Association (see Attachment 1).

This letter serves (1) to confirm applicability of the blanket waivers issued by Secretary Azar of the Department of Health and Human Services and CMS, which have been made retroactively effective to March 1, 2020, and (2) as a request of additional waivers, included herein, to be applied retroactively to March 1, 2020, applicable to all affected patients and providers in Utah in response to the COVID-19 pandemic.

In addition, Utah requests that any approved flexibility granted for our fee-for-service program and providers would also apply equally to our various federally approved delivery systems, such as our managed care plans, Utah's standalone Children's Health Insurance Program and services provided by IHS, Tribal or Urban Indian health service providers.

The list below represents Utah's initial requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency. Because circumstances surrounding the COVID-19 emergency are quite fluid, Utah may request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered.

Please contact Krisann Bacon (801)538-6079 or krisannbacon@utah.gov if you need additional information. Utah greatly appreciates your prompt attention to this request and we look forward to our continued partnership as we work together during this difficult time.

Sincerely:

Joseph K. Miner, MD

Joseph K. Miner, M.D.
Executive Director
Utah Department of Health

STATE OF UTAH

REQUEST FOR SECTION 1135 WAIVER FLEXIBILITIES TO ADDRESS COVID 19

1. General Flexibility Requests

1.1. **Shortages of PPE, Supplies, Drugs**. Permit flexibility, consistent with industry guidance, related to conservation of scarce resources and utilization of flexible approach to reduced supplies of necessary equipment, including the use of expired products, reuse of PPE, etc.

1.2. **340B Eligibility.** The State requests a limited waiver of the 340B Hospital Medicare DSH eligibility threshold for current 340B hospitals responding to the COVID-19 national health emergency and experiencing a significant change in patient mix would help ensure that hospitals do not lose their 340B status in the future as a result of a time-limited change in patient mix.

1.3. **Physician Self-Referral.** Waive sanctions for violations under Section 1877 of the Social Security Act to ensure appropriate physician availability for the provision of patient care.

1.4. **Flexibility for Teaching Hospitals**. Medicare generally requires that a teaching physician be physically present in the room/area with the patient and medical resident in order to bill as the teaching physician. Because hospitals are running low on PPE and also want to limit exposure of both patients and staff to other people as much as possible, we request flexibility in this requirement. Flexible approaches might include real-time audio/video or supervision through a window for the teaching physician. These flexible approaches should be covered and reimbursed.

1.5. **Feeding Assistant Training:** We request a waiver of certain requirements for paid feeding assistants to enable facilities to expand capacity to meet residents' needs during the emergency. Allow nursing facility to use Temporary feeding assistants who have completed an online training program of at least 1 hour by a state designated organization. Temporary feeding assistants employed during the waiver period, including a post-emergency period, shall continue training in a state approved training course. Please note, we are only requesting flexibilities related to requirements for state approved training; §483.60(h)(1)(i)-(ii). As the health and safety of residents is imperative, facilities will continue to ensure compliance with requirements at §483.60(h)(2)(i) and §483.95(h).

1.6. **Training Requirements 42 CFR §483.95.** The State requests a waiver for §483.95(g) required in-service training for nurse aides. The State recognizes that the CMS blanket waivers have been granted for §483.35, this request is specific to §483.95(g).

1.7. **Training and Certification of Nurse Aides.** CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d).

1.7.1. The State recognizes that CMS has granted waivers for many of these requirements as articulated above. The State's request of a waiver of the requirements for facility hiring and use of nurse aides as codified at §483.35(d)(1)-(7), to enable facilities to expand their staffing capacity to meet residents' needs during the emergency is articulated below:

1.7.1.1. In lieu of successful completion of a NATCEP or NACEP, administered by the state, nurse aide training and written exams will be allowed to be administered online through state designated organizations.

1.7.1.1.1. In lieu of the current requirements at §483.152, temporary nurse aides will be able to complete an online training program of at least 8 hours provided by a state designated organization, pass an online examination, and receive no less than 2 hours of supervised training by a member of nursing staff at the facility after hire. Training will include but not be limited to activities of daily living, infection prevention and control, documentation, and comfort care.

1.7.1.1.2. In lieu of the current requirements at §483.154, nurse aides must successfully complete an online examination.

1.7.1.2. An overwhelming majority of state approved NATCEPs and testing centers have been subject to closure and/or limited to online education, restricting their ability successfully to complete required training. To ensure residents continue to receive necessary cares and services, facilities must have flexibilities in the hiring of nurse aides. In the immediate future, it is improbable that newly hired nurse aides will be enrolled in a state approved NATCEP and equally improbable for the newly employed nurse aides to become certified and placed on the nurse aide registry within the 120-day requirement.

1.7.1.3. During this emergency, the unemployment rate in Utah rose 2000% in only a few weeks. As such, individuals previously certified as nurse aides are seeking employment in long term care. The state of Utah will waive requirements for an individual whose certification has lapsed, if they have not provided nursing or nursing related services within the previous twenty-four months, if the individual's certification was in good standing at the time renewal was required. However, flexibility to federal regulations must be provided to reinstate the certification for these valuable individuals.

1.7.1.4. Allow current nursing students who have completed at least one clinical rotation to be eligible for hire as a nurse aide. These candidates will not require state testing or registry status, as those will not be able to be performed during this pandemic due to state testing facility closures.

1.8. **Fingerprinting and other related services.** Due to closures of fingerprinting facilities and other related services, temporarily waive requirements for pre-hire screening, completion of criminal background checks which may include fingerprinting and provisions required under the national background check program.

1.9. **Continuous home health care 42 CFR §424.22.** For the period of the COVID-19 outbreak, in addition to acute symptom management for the patient, family caregiver illness could be a reason for care to be provided at home for the patient on a continuous basis. The State requests a waiver for the recertification timing and signature requirements.

1.10. **Continuous in-home hospice care 42 CFR §418.204.** During the COVID-19 outbreak, the requirements for continuous home care and the description of periods of crisis must change, as hospices may need additional flexibility to continue to care for patients in their homes. If the patient is symptomatic of having COVID-19 infection, the hospice should work to keep the patient at home when possible, rather than sending them to a facility for inpatient care. In addition, patients may need to remain at home with more intensive hospice support for a period of in-home respite care to mitigate exposure risk for others in the community. The State requests flexibility in the max hours and period.

1.11. **Continuous home care 42 CFR §418.302.** The State requests a waiver of Reduce the minimum hour requirement for continuous home care from a minimum of 8 hours to a minimum of 4 hours during the COVID-19 outbreak.

1.12. **Nursing staff 42 CFR § 418.64.** Allow contracting for nursing staff to provide continuous home care.

1.13. **Staffing ratio requirements 42 CFR §418.64 and additional CMS policy.**. Remove the staffing ratio requirement to allow hospices to determine the ratio of nursing and aide services necessary to meet the individual needs of patients and families on a case-by-case basis.

1.14. **Telehealth billing.** The State requests that the telehealth services for Medicare recipients recently granted for home health agencies to provide be billable through Medicare by the home health agencies.

1.15. **Low-utilization payment adjustments 42 CFR § 484.230.** The State requests that home health services provided via permissible telehealth options be eligible in the calculation of low utilization payment adjustment (LUPA) thresholds. Without this provision, home health providers would not be able to bill for any services provided to patients who are not accessible for in-person visits due to COVID-19 restrictions or precautions prescribed by their physician.

2. Opening a COVID 19 Facility

2.1. **Physical Environment**. CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623. Non-SNF/NF buildings/space can be certified for use as a temporary SNF/NF, provided sufficient safety and comfort is provided for residents and staff – allows state to open a temporary COVID 19 nursing facility to assist COVID 19 positive SNF/NF residents to receive SNF/NF care and services during treatment for virus while protecting other vulnerable

adults. This is another measure that will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. It will also promote appropriate cohorting of COVID-19 residents.

2.2. **Temporary Facilities.** For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 (as noted elsewhere in this waiver document) and the provider- based department requirements at §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. This extends to any entity operating as a hospital (whether a current hospital establishing a new location or an Ambulatory Surgical Center (ASC) enrolling as a hospital during the PHE pursuant to a streamlined enrollment and survey and certification process) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.

3. HIPAA Regulations waiver requests. Allow non-HIPAA compliant telehealth modes to allow providers to use readily available platforms, including Facetime, WhatsApp, Skype, etc., to facilitate a telehealth visit or check-in at the location of the patient, including the patient's home.

3.1. **Patient rights.** The State requests a waiver of enforcement of patient rights related to personal privacy, confidentiality, orders for seclusion, and patient visitation rights to undertake public emergency responses that are not otherwise possible.

3.2. **HIPAA noncompliance**. Waive HIPAA sanctions and penalties arising from noncompliance with certain HIPAA privacy regulations, including: obtaining a patient's agreement to speak with family or friends or honoring a patient's request to opt out of the facility directory; distributing a notice of privacy practices; and/or the patient's right to request confidential communications; and

3.3. **Code sets.** Request to waive HIPAA EDI code set requirements 45 CFR Part 162.1002. This would allow Utah the flexibility to define and implement code sets not currently available in a standard federal code set, or provide additional specificity to a code set definition that allows Utah to track and set rates for services specific to COVID-19.

4. Laboratory Considerations. Any location in which a healthcare professional who is licensed or certified in anatomic pathology, clinical pathology, or other areas of laboratory medicine to provide professional services in such location. Such waiver would be in effect for the duration of the declared national emergency. The work that is to be performed remotely is in line with the applicable job descriptions and includes, but is not limited to:

4.1. Review of cases by means of glass slides or digital imaging in order to render a diagnosis for a patient

4.2. Provide a professional consultation on cases from clients being sent to ARUP Laboratories for review

4.3. Result and data entry into the applicable computer systems (e.g. Cerner Millennium, Epic) and sign out of cases

4.4. Peer consultation

4.5. Intraoperative consultation

4.6. Allow providers to administer point of care tests in the community

5. **ERISA Health Plans.** The State requests that HHS and the Department of Labor and/or the Internal Revenue Service as applicable, compel ERISA health plans to pay for COVID-19 diagnostic testing and treatment at 132% of current Medicare rates. Waive cost-sharing related to COVID-19 testing and treatment and allow for out-of-network provider payments.

6. Medicaid and CHIP Waiver Requests

6.1. Provider participation, billing requirements and conditions for payment

6.1.1. **Provider enrollment.** Waiver of certain provider enrollment requirements in order to maintain capacity to meet beneficiary access needs during the emergency and to enable payment to affected providers for rendered services.

6.1.2. As an initial matter, DMHF proposes to waive requirements such as: application fees pursuant to 42 CFR §455.460; criminal background checks associated with fingerprint-based Criminal Background Checks pursuant to 42 C.F.R §455.434; site visits pursuant to 42 C.F.R §455.432; screening levels pursuant to 42 CFR §424.518; in-state/territory licensure requirements 42 C.F.R §455.412 and disclosures and disclosure statement pursuant to 42 CFR §455.104.

6.1.3. **Enrollment and screening of providers 42 CFR §455.410**. During the approved emergency period, DMHF proposes to streamline enrollment of providers using relatively limited information, i.e. provider information sufficient to build a case file for claims processing. DMHF would apply such flexibility to providers on a statewide basis, and would require provider agreements but not disclosure statements. DMHF would deny enrollment under this streamlined process if a provider is found on the following exclusionary databases: SSA Death Master File, NPPES, LEIE, EPLS, SAM and PECOS.

6.1.4. **Application fee 42 CFR §455.460.** Waive requirements for an application fee prior to executing a provider agreement.

6.1.5. **Reactivation of provider enrollment 42 CFR §455.420.** Waive application fee and re-screen requirements for providers to reactivate.

6.1.6. **Revalidation of enrollment 42 CFR §455.414.** Temporarily cease the revalidation of and waive provider renewal requirements during this state of emergency. Waiver/flexibility with MCO and PIHP requirements to complete credentialing of providers required under 42 CFR § 438.214.

6.1.7. **Provider payments in alternative settings.** Waiver/flexibility 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.

6.1.8. **Site visits 42 CFR §455.432.** Waive requirements for site visits designated as 'moderate' or 'high' categorical risks to the Medicaid program.

6.1.9. **Provider Agreements and Direct Payment to Providers.** Waive section 1902(a)(32) To permit the provision of care to affected beneficiaries by individuals or entities who have not executed a Provider Agreement with the State in the event the need arises.

6.1.10. **Out-of-state Providers**. Temporarily waive requirements that out-of-state providers be licensed in Utah when they are licensed by another state Medicaid agency or by Medicare. If a provider is enrolled with another state's Medicaid program, waive requirement that the provider be enrolled with Utah Medicaid allowing them to offer both emergency and non-emergency services to Medicaid enrollees.

6.1.11. **Provider Location.** Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.

6.2. **Telehealth.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a)(8)(9) for hospitals and §485.616(c) for CAHs. CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options. §494.90(b)(4). CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.

6.2.1. In addition, the Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary to waive certain Medicare telehealth payment requirements during the PHE the Secretary declared on January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

6.2.2. As stated in specific areas of this request, the State requests waivers for all related face-to-face or in person requirements for providers where clinically appropriate.

6.3. Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units. CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatients. The State requests this be applicable for Medicaid beneficiaries.

6.4. Psychiatric Hospitals

6.4.1. Patient seclusion 42 CFR 482.13(e). The State is requesting the ability to seclude a patient who must be isolated or quarantined due to exposure from Covid-19, or a positive Covid-19 test if they are unwilling to isolate themselves. We would also request a waiver for documentation requirements for seclusion in these cases.

6.4.2. Special staffing requirements for psychiatric hospitals. We are requesting these be waived in case we must utilize non-infected and/or non-exposed staff members more broadly than we normally would. For example, increasing our nurse to patient ratio, or pulling therapists to perform safety watches. If we increased our nurse to patient ratio, it would likely be one nurse for every two units, rather than one nurse for every unit. We would assign the one nurse to supervise two units that are next to each other.

6.4.3. Grievances 42 CFR 482.13(a)(2). The hospital must establish a process for prompt resolution of patient grievances, and specify the time frames for review of the grievance and provision of response." The State is requesting this be waived.

6.4.4. Consolidation of patient observation 42 CFR 482.13(c)(2). We would like the flexibility to consolidate observation statuses for some patients due to a potential staffing shortage caused by the virus. For example, we may consolidate two 1:1 (staff-to-patient) to a 1:2 (staff-to-patient ratio.)

6.5. Institution for Mental Disease

6.5.1. Waive all IMD requirements in order to maintain continuity of care for individuals in all care sites while awaiting other care sites that might not otherwise be available due to the emergency.

6.5.2. Waive strict application of ASAM criteria for SUD treatment.

6.6. Home Health and Hospice Care

6.6.1. Home health certifications and initial assessments 42 CFR § 484.55(a) Home health agencies can perform certifications, initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment while supporting infection control and reducing impact on acute care and long-term care facilities. This will allow for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

6.6.2. **Telehealth.** The State recognizes that waivers for telehealth have been granted and the State has the flexibility to implement telehealth policy related to Medicaid. This request is to ensure that all barriers are removed for care during this period. When home visits are restricted by quarantine or self-isolation, or not allowed due to restrictions on facility/community access, allow certain home health and hospice interventions to be performed via phone or video conferencing devices to minimize the risk of virus exposure and of re-hospitalization due to restricted care. Our request, which includes access to nursing, therapy, social work, and chaplain services, is consistent with telehealth waivers that have already been granted to physicians and other professional healthcare providers.

6.6.3. **Electronic Visit Verification.** Section 12006(a) of the 21st Century Cures Act mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. The State is requesting these requirements be waived.

6.6.4. **Expanded eligibility 42 CFR §440.70 and §441.15.** Temporarily expand eligibility to in-home services for an individual who does not meet functional eligibility, as specified in (b) of this CFR, when a congregate site such as an adult day health center closes. The State requests an additional waiver for the physician plan of care reviews.

6.6.5. **Home Health Diagnostic Testing**. For Medicaid and CHIP, reimburse Home Health providers to test individuals who may be COVID 19 in their homes for both fee for service and managed care. Additional home health and hospice requests are found elsewhere in this submission document.

6.7. Provider participation, billing requirements and conditions for payment ICF/IID –

6.7.1. **Patient movement.** Waiver/flexibility to allow receiving facilities or alternate settings to receive ICF/IID payment if a client is moved to a specialty facility to receive care and recover from COVID19 during the COVID-19 crisis.

6.7.2. **Personal protective equipment.** If personal protective equipment is unavailable due to supply chain disruption, allow reasonable alternative protective measures. For example, regulations require staff to wear a paper gown when disposing of certain hazardous drugs. If paper gowns become unavailable, allow staff to wear washable gowns when disposing of hazardous medications

6.7.3. **Staffing**. Authorize facilities to adjust staffing patterns if doing so is necessary for staff to meet residents' basic health and safety needs.

6.7.4. **Community outings**. Authorize facilities to suspend community outings.

6.7.5. **Social distancing measures.** Authorize facilities to implement social distancing precautions to prevent individuals who are not directly involved in client care from entering the property. Authorize the facility to implement social distancing precautions with respect to on and off-campus movement.

6.7.6. Resident assessments. Authorize facilities to suspend assessment and documentation requirements that are not necessary to maintain the residents' basic health and safety."

6.7.7. Specially constituted committees. Suspend all requirements related to the specially constituted committees.

6.7.8. Special services. Suspend specialized services to prevent facility vendors from becoming disease vectors.

6.7.9. Routine services. Authorize facilities to reschedule routine or elective medical and dental appointments.

6.7.10. Facility housing requirements. Suspend requirement facilities relating to housing clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. This will allow for the temporary housing of COVID 19+ clients together to limit the exposure to non-infected clients.

6.7.11. Adult training programs. Authorize facilities to suspend adult training programs and active treatment to meet health and safety needs.

6.7.12. Telehealth. Conduct resident medical, dental, or behavioral health appointments via telehealth when available.

6.8. Long Term Acute Care. Suspend the prior authorization requirement for this service

6.9. Transparency

6.9.1. Tribal Consultation. Allow the State to modify the tribal consultation process by shortening the number of days before submission of the state plan amendment (SPA) and/or conducting consultation after submission of the SPA.

6.9.2. Requirements for public notice as applicable to the authorities selected for this demonstration.

6.10. Eligibility

6.10.1. Self-Attestation. Allow self-attestation for all eligibility criteria (excluding citizenship and immigration status) on a case-by-case basis for Medicaid and CHIP eligible individuals subject to a disaster when documentation is not available as outlined at 42 CFR 435.952(c)(3); 42 CFR 457.380.

6.10.2. Presumptive eligibility. Allow presumptive eligibility for the Aged, Blind and Disability population for long term care services based on an abbreviated level of care assessment and financial eligibility screening to ensure more immediate discharge from hospitals of people who are ready but must await application for long term care benefits so we can free hospital beds more timely. Also, we request the state to be established as a PE entity to enroll applicants based on preliminary application information.

6.10.3. **Presumptive eligibility**. Allow presumptive Medicaid eligibility for the Aged, Blind, and Disabled population.

6.10.4. **Treatment of Assets.** Waive the asset limit for the Aged, Blind and Disabled program for individuals with a COVID 19 diagnosis needing care in a skilled nursing facility after hospitalization.

6.10.5. **Redetermination timelines.** Extend redetermination timelines for current Medicaid and CHIP enrollees in the state to maintain continuity of coverage as permissible under 42 CFR 435.912(e).

6.10.6. **Enhanced Income Eligibility.** The State requests the ability to enhance income eligibility levels for those uninsured under the crisis period.

6.10.7. **Lift the 5-year bar period.** Allow the state to remove the Five-year bar for legally admitted individuals.

6.10.8. **Annual Redeterminations of Eligibility** – Sections 1902(a)(4) and1902(a)(19). To permit delay of otherwise required redeterminations for the State's XIX program.

6.10.9. **Eligibility Appeals**. Allow 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)

6.10.10. **Proper and Efficient Administration of the State Plan** - Section 1902(a)(4)(A). To enable the State to use streamlined eligibility procedures for individuals who would be affected Beneficiaries.

6.10.11. **Reasonable Promptness Section 1902(a)(8)**. To enable the State to limit enrollment or to reasonably triage access to needed long-term services and supports for affected Beneficiaries.

6.10.12. **Reasonable Standards for Eligibility Section 1902(a)(17)**. To enable the State to modify eligibility criteria as necessary to make individuals affected beneficiaries in need of long-term services and supports.

6.10.13. **Post Eligibility Treatment.** Requirements related to the post eligibility treatment of income which will enable affected beneficiaries to retain funds otherwise required to be collected (42 CFR 435.217)

6.10.14. **Conflict of interest.** Requirements related to conflict of interest and person-centered plan development in order to enable sufficient provider capacity to serve affected beneficiaries as applicable to the authorities selected for this demonstration.

6.11. Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

6.11.1. **Residency Assessment.** Consider Medicaid and CHIP enrollees who are quarantined from the state as "temporarily absent" when assessing residency in

order to maintain enrollment (for home state where disaster occurred or public health emergency exists) as permissible under 42 CFR 435.403(j)(3); 42 CFR 457.320(e); 42 FR 431.52; 42 CFR 457.320.

6.11.2. **Levels of care.** The State requests flexibility in admitting individuals to nursing facilities when needed despite the level of care criteria.

6.12. **Face-to-face requirements 42 CFR §440.70.** The State requests waivers for face-to-face requirements found in 42 CFR §440.70.

6.13. **Medicaid in Schools**

6.13.1. Due to the closure of school facilities, allow school districts to bill per number of school days in the month instead of actual days attended because students are out of schools and school districts are not keeping official attendance records during this emergency period while children are continuing their education at home.

6.13.2. Allow school districts to use previous time study results within the past twelve months for the purpose of Medicaid administrative claiming if the Utah statewide school facility closure is extended through the end of the school year.

6.14. **Cost sharing.** Waive requirement that the State must submit and receive CMS approval of a Title XIX or Title XXI state plan amendment in order to temporarily waive any patient cost sharing associated with COVID-19 screening, testing, and treatment.

6.15. **Medicaid Enterprise Systems Certification 42 CFR §433.110 - 433.131.** The state is requesting that the Medicaid Enterprise System Certification process for new and existing systems be suspended during the public health emergency period.

6.16. **Federal financing**. We request authority to allow the state to draw federal financing match for payments, such as hardship or supplemental payments, to stabilize and retain providers of Behavioral Health and/or Long-Term Care settings (including home care workers) who suffer extreme disruptions to their standard business model and/or revenue streams as a result of the public health emergency.

6.17. **Medicaid administrative claiming and the cost allocation plan.** The State requests authority to expand the federal match for administrative costs related to COVID 19 not specified in a MAC or cost allocation plan.

6.18. **Statewideness.** Section 1902(a)(1) and 1902(a)(17). To enable the State to vary services and service delivery methods in geographic regions as appropriate for affected Beneficiaries.

6.19. **Comparability.** Section 1902(a)(10)(B). To enable the State to deliver different services and service delivery methods to affected beneficiaries than are otherwise available to non-affected Beneficiaries.

6.20. **Fair Hearings and Notices.** Section 1902(a)(3). To enable the State to extend fair hearing timeframes as needed.

6.21. **Freedom of Choice**. Section 1902(a)(23)(A). To enable the State to restrict freedom of choice of provider.

6.22. **Cost and budget neutrality requirements pursuant to 1915(c) and 1115** and limitations on numbers of individuals served in order to enable the state to deliver long-term services and supports as needed to affected beneficiaries [1915(c)(2)(D)]. States will not be required to meet budget neutrality tests under the waiver during the period of the emergency.

6.23. **Expenditure authority** is requested under section 1115(a)(2) of the Act to allow the following expenditures, which are not otherwise included as expenditures under section 1903, to be regarded as expenditures under the State's title XIX plan.

6.23.1. Payment for home delivery or mailing of pharmacy prescriptions

6.23.2. Flexibility in upper payment limits, suspension of the cap

6.23.3. Retainer payments or Supplemental payments for providers

6.23.4. Any additional expenditures issued under this waiver

6.23.5. Necessary exceptions to covered outpatient drug requirements for drug shortages

6.23.6. Payment for emergency transportation services related to non-emergent essential services such as dialysis for COVID-19 positive patients.

6.24. **Reporting.** Waive timelines and grant leeway for all reports, required surveys, notifications and licensing visits. The state believes most of this may be covered in the blanket waiver outlined above, for clarity, the state requests a blanket waiver authority for the following:

6.24.1. Adjusting performance deadlines and timetables for required reporting and oversight activities;

6.24.2. Temporarily delaying, modifying or suspending CMS-certified facilities' onsite survey, recertification and revisit surveys conducted by the State survey agency, and some enforcement actions, and/or allowing additional time for facilities to submit plans of correction, and waiving state performance standards and requirements for the current federal fiscal year;

6.24.3. Temporarily delay due dates for annual upper payment limit demonstrations.

6.25. **Flexibility in claim throughput requirements 42 CFR §447.45.** DMHF staff are currently working from home per Governor Herbert's directive. This may impact the requirement to process 90% of clean claims in 30 days and 99% in 90 days.

6.26. **Timely claims payment 42 CFR §447.45(2)(d).** The State requests flexibility in the requirement for providers to submit all claims no later than 12 months from the date of service.

6.27. **Home and community-based settings 42 CFR 441(b)(1)(ii)** Requirements prohibiting the provision of home and community-based services to affected beneficiaries who are being served in an inpatient setting in order to enable direct care workers or other home and community-based providers to accompany individuals to any setting necessary.

6.28. **Home and community-based settings 42 CFR 441.301(c)(4)**. Requirements related to home and community-based settings in order to ensure the health, safety and welfare of affected beneficiaries.

6.29. **Signature requirements.** Waive signature requirements on level of care assessments, plans of care and other required supporting documentation.

6.30. **Medicare and Medicaid**. Medicaid requests the same waivers for Medicare services as applicable generally and specifically for the telehealth provisions requested in the telehealth section of this document.

6.31. **Delivery of Services in Alternate Clinic Locations**. The State requests a waiver to allow Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services at alternative physical settings, such as a mobile clinic or temporary location. This will allow flexibility in site of clinics to promote appropriate infection control.

6.32. **Amount, Duration, and Scope Section 1902(a)(10)(B**). To the extent necessary to enable the state to offer different benefits to affected beneficiaries.

6.33. **Non-Emergency Medical Transportation (NEMT) 42 CFR 170(4).** Waive 42 CFR 170(4) requirements, which currently prohibits contracted transportation brokers from directly providing trips to Medicaid clients.

6.33.1. For Medicaid, allow the state to reimburse individuals to provide transportation for individuals who may be COVID 19 positive to testing sites.

6.33.2. Allow reimbursement for ‘wait time’ if a driver is waiting for an individual to get tested at a specimen collection site.

6.34. **Prescribed drugs, dentures, prosthetic devices, and eyeglasses 42 CFR § 440.120.** The State requests FFP for drugs provided by manufacturers not participating in the Medicaid drug rebate program in cases where pharmacies are unable to procure the same drug from a participating manufacturer for the duration of the public health emergency.

6.35. **Verbal signatures.** Waive physical signature requirement for services via any method of delivery to the patient.

6.36. **Documentation of access to care and service payment rates 42 CFR §447.203.** The State requests flexibility in documentation requirements for the duration of the public health emergency.

6.37. **Coverage for the Uninsured.** The State requests CMS to provide100% federal financial participation match for coverage of COVID-19 related diagnostics and treatment for the uninsured.

6.38. Utilization control 42 CFR PART 456. The State requests flexibility in utilization control activities for the duration of the public health emergency.

6.39. Managed Care Organizations, Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans

6.39.1. Actuarial soundness. Due to the extraordinary nature of this emergency, we request a waiver of the requirement for actuarially sound Medicaid managed care rates, under 42 CFR Part 438, for rate setting associated to contract amendments within calendar years 2020 and 2021. This waiver would apply to all Medicaid managed care programs and contracts. An important element of this request is allowing, particularly smaller and more vulnerable providers like behavioral health providers, ability to be paid if they have not been able to perform services due to quarantine.

6.39.2. Timely claims payment by MCOs 42 CFR §447.46. The State requests a waiver of contractual obligations by the MCOs if claims, particularly paper claims are unable to be processed within the timeframes agreed to in the contract.

6.39.3. Network adequacy standards 42 CFR §438.68. Waiver of network adequacy standards that could conflict with the ability of providers to be able to provide necessary and timely care to beneficiaries experiencing COVID-19 symptoms.

6.39.4. Availability of services 42 CFR §438.206. The State requests a waiver of availability of service standards under 42 CFR 438.206 that could conflict with the ability of providers to be able to provide necessary and timely care to beneficiaries experiencing COVID-19 symptoms.

6.39.5. Enrollee rights 42 CFR §438.100. The State requests waiver of enforcement of enrollee rights related to personal privacy, confidentiality (see HIPAA request below), orders for seclusion, and patient visitation rights.

6.39.6. Resolution and notification: Grievances and appeals 42 CFR §438.408. The State requests modification of the timeframe for managed care entities to resolve appeals under 42 C.F.R. §438.408(f)(1) before an enrollee may request a State fair hearing to no less than one day in accordance with the requirements specified below; this allows 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. Additionally, the State requests modification of the timeframe under 42 C.F.R. §438.408(f)(2) for enrollees to exercise their appeal rights to allow an additional 120 days to request a fair hearing when the initial 120th day deadline for an enrollee occurred during the period of this section 1135 waiver.

6.39.7. Activities related to external quality review 42 CFR §438.408. The State requests a waiver regarding the timely completion of external quality review (EQR) activities required under 42 CFR § 438.358 performed by the EQRO and required network validation activities.

6.39.8. Disclosure by Medicaid providers and fiscal agents: Information on ownership and control 42 CFR §455.104. Waive disclosure statement required by 42 CFR 455.104 for the duration of the crisis.

6.39.9. Standard contract requirements 42 CFR §438.3. Waiver of the timeframe required for submission of contracts to CMS under 42 CFR 438.3

6.39.10. HEDIS and CAHPS Data: Allow adjustments to performance deadlines, time tables, and performance standards for Managed Care Quality Reporting of HEDIS 2020 measures from the 2019 measurement year.

6.39.10.1. When the lack of proper documentation review results in lowered HEDIS scores on hybrid measures, allow use of the HEDIS 2019 measures for performance evaluation.

6.39.11. Allow adjustments to performance deadlines, time tables, and performance standards for Managed Care Quality Reporting through CAHPS for the 2019 measurement year.

7. Blanket Waivers Issued by CMS, includes some clarifying requests. The following are included in the CMS blanket waivers issued on March 30, 2020. A full list of blanket waivers issued by CMS can be found on the CMS website. Below is a list of requests from stakeholders in the State that were included in the waivers issued on March 30, 2020. A separate request will not be made by the State, however, the State requests that where applicable these waivers apply to Medicaid providers and beneficiaries in addition to Medicare.

7.1. Emergency Medical Treatment and Active Labor Act. CMS is waiving the enforcement of section 1867(a) of the Act. This will allow hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state's emergency preparedness or pandemic plan.

7.2. Detailed Information Sharing for Discharge Planning for Hospitals and CAHs. CMS is waiving the requirement 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to provide detailed information regarding discharge planning.

7.3. Limiting Detailed Discharge Planning for Hospitals. CMS is waiving all the requirements and subparts at 42 CFR §482.43(c) related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings.

7.4. Patient Rights. CMS is waiving requirements under 42 CFR §482.13 only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19. Hospitals that are located in a state which has widespread confirmed cases (i.e., 51 or more confirmed cases*) as updated on the CDC website, CDC States Reporting Cases of COVID-19, at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html, would not be required to meet specific requirements outlined in the CMS blanket waiver document.

7.5. **Telehealth.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a)(8)–(9) for hospitals and §485.616(c) for CAHs. CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options. §494.90(b)(4). CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.

7.5.1. In addition, the Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary to waive certain Medicare telehealth payment requirements during the PHE the Secretary declared on January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

7.6. **Physical Environment**. CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623. There are additional provisions relating to requirements under 42 CFR 483.90 for skilled nursing and long-term care.

7.7. **Anesthesia Services.** CMS is waiving requirements under 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician.

7.8. **Sterile Compounding**. CMS is waiving requirements (also outlined in USP797) at 42 CFR §482.25(b)(1) and §485.635(a)(3) in order to allow used face masks to be removed and retained in the compounding area.

7.9. **Verbal Orders**. CMS is waiving the requirements of 42 CFR §482.23, §482.24 and §485.635(d)(3) to provide additional flexibility related to verbal orders where readback verification is required, but authentication may occur later than 48 hours.

7.10. **Reporting Requirements**. This applies to specific hospital reporting. There is a provision for home health agencies related to OASIS Transmission.

7.11. **Medical Staff**. CMS is waiving requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and approval to address workforce concerns related to COVID-19. CMS is waiving §482.22(a)(1)-(4) regarding details of the credentialing and privileging process.

7.12. **Physician Services**. CMS is waiving requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4).

7.13. **Nursing Services.** CMS is waiving the requirements at 42 CFR §482.23(b)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present.

7.14. **Food and Dietetic Services.** CMS is waiving the requirement at paragraph 42 CFR §482.28(b)(3), which requires providers to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge capacity sites.

7.15. **Respiratory Care Services.** CMS is waiving the requirements at 42 CFR §482.57(b)(1) that require hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures.

7.16. **Critical Access Hospital (CAH) Personnel Qualifications.** CMS is waiving the minimum personnel qualifications for clinical nurse specialists at paragraph 42 CFR §485.604(a)(2), nurse practitioners at paragraph §485.604(b)(1)–(3), and physician assistants at paragraph §485.604(c)(1)–(3).

7.17. **CAH Staff Licensure.** CMS is deferring to staff licensure, certification, or registration to state law by waiving 42 CFR §485.608(d) regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations. This waiver will provide maximum flexibility for CAHs to use all available clinicians.

7.18. **CAH Status and Location.** CMS is waiving the requirement at 42 CFR §485.610(b) that the CAH be located in a rural area or an area being treated as being rural, allowing the CAH flexibility in the establishment of surge site locations. CMS is also waiving the requirement at §485.610(e) regarding the CAH's off-campus and co-location requirements, allowing the CAH flexibility in establishing temporary off-site locations. In an effort to facilitate the establishment of CAHs without walls, these waivers will suspend restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs.

7.19. **CAH Length of Stay.** CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay at 42 CFR §485.620.

7.20. **Temporary Expansion Locations.** For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 (as noted elsewhere in this waiver document) and the provider- based department requirements at §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the PHE. This waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. This extends to any entity operating as a hospital (whether a current hospital

establishing a new location or an Ambulatory Surgical Center (ASC) enrolling as a hospital during the PHE pursuant to a streamlined enrollment and survey and certification process) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.

7.21. **Practitioner Locations.** The State is requesting this waiver apply to the Medicaid program in addition to Medicare.

7.22. **Provider Enrollment.** This applies to Medicare enrollment, the State has specific requests for the Medicaid program in this document.

7.23. **Utilization Review.** CMS is waiving certain requirements under 42 CFR §482.1(a)(3) and 42 CFR §482.30.

7.24. **CMS IT System Certification.** Waive CMS system certification requirements for Utah's Medicaid Management Information System known as PRISM.

7.25. **Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments.** CMS is waiving 42 CFR §482.12(f)(3), emergency services, with respect to surge facilities only. More details can be found in CMS blanket waivers issued on March 30, 2020.

7.26. **Emergency Preparedness Policies and Procedures.** CMS is waiving 42 CFR §482.15(b) and §485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and §482.15(c)(1)–(5) and §485.625(c)(1)–(5) which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements with respect to the surge site.

7.27. **Quality Assessment and Performance Improvement Program.** CMS is waiving 42 CFR §482.21(a)–(d) and (f), and §485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated Quality Assurance & Performance Improvement programs (for hospitals that are part of a hospital system).

7.28. **Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units.** CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatients.

7.29. **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital.** CMS is allowing acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency.

7.30. **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital.** CMS is allowing acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE. The state is requesting that this provision apply to Medicaid as well.

7.31. Flexibility for Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule". CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such.

7.32. Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission. CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. Completed 2019 Occupational Mix Surveys, Hospital Reporting Form CMS-10079, for the Wage Index Beginning FY 2022, are due to the Medicare Administrative Contractors (MACs) on the Excel hospital reporting form available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html by July 1, 2020. CMS is currently granting an extension for hospitals nationwide affected by COVID-19 until August 3, 2020.

7.33. Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs). This allows a LTCH to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement, which allows these facilities to be paid as LTCHs.

7.34. Care for Patients in Extended Neoplastic Disease Care Hospitals. CMS is allowing extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay requirement, which allows these facilities to be excluded from the hospital inpatient prospective payment system and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules as authorized under Section 1886(d)(1)(B)(vi) of the Act and §42 CFR 412.22(i).

7.35. Medical Records. CMS is waiving requirements under 42 CFR §482.24(a) through (c).

7.36. Flexibility in Patient Self Determination Act Requirements (Advance Directives). CMS is waiving the requirements at sections 1902(a)(58) and 1902(w)(1)(A) of the Act (for Medicaid); 1852(i) of the Act (for Medicare Advantage); and 1866(f) of the Act and 42 CFR §489.102 (for Medicare).

7.37. Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

7.37.1. Reporting Minimum Data Set. CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

7.37.2. Staffing Data Submission. CMS is waiving 42 CFR 483.70(q) to provide relief to long-term care facilities on the requirements for submitting staffing data.

7.37.3. 3-Day Prior Hospitalization. Using the authority under Section 1812(f) of the Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services

without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances)

7.37.4. **Waive Pre-Admission Screening and Annual Resident Review (PASARR).** CMS is waiving 42 CFR 483.20(k) allowing states and nursing homes to suspend these assessments for new residents for 30 days.

7.37.5. **Resident Groups.** CMS is waiving the requirements at 42 CFR 483.10(f)(5), which ensure residents can participate in-person in resident groups.

7.37.6. **Physician Visits in Skilled Nursing Facilities/Nursing Facilities**. CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

7.37.7. **Resident roommates and grouping.** CMS is waiving the requirements in 42 CFR 483.10(e) (5), (6), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19.

7.37.8. **Resident Transfer and Discharge**. CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i) (with some exceptions) to allow a long-term care (LTC) facility to transfer or discharge residents to another LTC facility. There are specific cohorting purposes outlined by CMS.

7.37.9. **Exceptions.** CMS outlines exceptions in the summary document starting on page 11.

7.38. End-Stage Renal Dialysis (ESRD) Facilities

7.38.1. **Training Program and Periodic Audits.** CMS is waiving the requirement at 42 CFR §494.40(a) related to the condition on Water & Dialysate Quality, specifically that on-time periodic audits for operators of the water/dialysate equipment are waived to allow for flexibilities.

7.38.2. **Defer Equipment Maintenance & Fire Safety Inspections.** CMS is waiving the requirement at 42 CFR §494.60(b) for on-time preventive maintenance of dialysis machines and ancillary dialysis equipment.

7.38.3. **Emergency Preparedness.** CMS is waiving the requirements at 42 CFR §494.62(d)(1)(iv).

7.38.4. Ability to Delay Some Patient Assessments. CMS is not waiving subsections (a) or (c) of 42 CFR §494.80, but is waiving requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility.

7.38.5. Time Period for Initiation of Care Planning and Monthly Physician Visits. CMS is modifying two requirements related to care planning.

7.38.6. Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation. CMS is waiving the requirement at 42 CFR §494.100(c)(1)(i) which requires the periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel.

7.38.7. Home Dialysis Machine Designation – Clarification. The ESRD Conditions for Coverage (CFCs) do not explicitly require that each home dialysis patient have their own designated home dialysis machine.

7.38.8. Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded. CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues due to COVID-19 and the need to mitigate transmission among this vulnerable population.

7.38.9. Dialysis Patient Care Technician (PCT) Certification. CMS is modifying the requirement at 42 CFR §494.140(e)(4) for dialysis PCTs that require certification under a state certification program or a national commercially available certification program within 18 months of being hired as a dialysis PCT for newly employed patient care technicians.

7.38.10. Transferability of Physician Credentialing. CMS is modifying the requirement at 42 CFR §494.180(c)(1) which requires that all medical staff appointments and credentialing are in accordance with state law.

7.38.11. Furnishing dialysis services on the main premises: ESRD requirements at 42 CFR §494.180(d) require dialysis facilities to provide services directly on its main premises or on other premises that are contiguous with the main premises. CMS is waiving this requirement to allow dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility.

7.38.12. Clarification for billing procedures. Typically, ESRD beneficiaries are transported from a SNF/NF to an ESRD facility to receive renal dialysis services. In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility.

7.39. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required.

7.40. Practitioner Locations. CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when specific conditions are met.

7.41. Home Health

7.41.1. Requests for Anticipated Payment (RAPs). CMS is allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.

7.41.2. Reporting. CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below:

7.41.2.1. Extending the 5-day completion requirement for the comprehensive assessment to 30 days.

7.41.2.2. Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

7.41.3. Initial Assessments. CMS is waiving the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term care facilities. This will allow for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

7.41.4. Waive onsite visits for HHA Aide Supervision. CMS is waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.

7.42. <u>Hospice</u>

7.42.1. Face-to-Face Encounter. Hospice patients are required to have a face-to-face visit with a hospice physician or nurse practitioner to determine continued eligibility for hospice benefits prior to recertification for the 3rd and each subsequent benefit period. CMS should issue immediate guidance permitting telephonic and telehealth-based encounters as an alternative to direct physician or nurse practitioner contact under the Medicare hospice face-to-face requirements during this period of emergency.

7.42.2. Time Frame for Completion of the Comprehensive Hospice Assessment

7.42.3. **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR §418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at §418.54(d). Hospices must continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.

7.42.4. **Waive Non-Core Services**. CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.

7.42.5. **Waive Requirement for Hospices to Use Volunteers**. CMS is waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.

7.42.6. **Waived Onsite Visits for Hospice Aide Supervision.** CMS is waiving the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.