

JAY INSLEE  
Governor



STATE OF WASHINGTON  
OFFICE OF THE GOVERNOR

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March 15, 2020

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

**SUBJECT: Request for Waivers Under Section 1135 of the Social Security Act**

Dear Ms. Glaze:

The State of Washington urgently requests that the Centers for Medicare and Medicaid Services (CMS) grant waivers of certain federal healthcare laws in response to the public health emergency surrounding the outbreak of the coronavirus disease 2019 (COVID-19). The specific statutory and regulatory waivers that the State and its partners in the healthcare community seek are outlined in the attached document.

On January 31, 2020, the Secretary of the Department of Health and Human Services (HHS) declared a nationwide public health emergency under Section 319 of the Public Health Service Act, 42 U.S.C. § 247d. On March 13, 2020, the President declared a national emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, *et seq.* These steps give authority to CMS to grant waivers to the State under Section 1135 of the Social Security Act, 42 U.S.C. § 1320b-5. To the extent CMS believes the waivers would be more appropriately granted under Section 1115 of the Social Security Act, 42 U.S.C. § 1315, then the State asks CMS to deem the requests to be made under that section as well.

As Governor of Washington, I have taken all necessary and appropriate action under State law to combat the outbreak, including an initial Proclamation on February 29, 2020, that a State of Emergency exists.<sup>1</sup> The Proclamation “direct[s] the plans and procedures of the Washington State Comprehensive Emergency Management Plan be implemented.” The Proclamation further directs State agencies “to utilize state resources and to do everything reasonably possible to assist affected political subdivisions in an effort to respond to and recover from the outbreak.” Finally, the Proclamation “order[ed] into active state service the organized militia of Washington State to include the National Guard and the State Guard[.]”

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<sup>1</sup> [https://www.governor.wa.gov/sites/default/files/20-05%20Coronavirus%20%28final%29.pdf?utm\\_medium=email&utm\\_source=govdelivery](https://www.governor.wa.gov/sites/default/files/20-05%20Coronavirus%20%28final%29.pdf?utm_medium=email&utm_source=govdelivery)

Subsequent to my initial declaration of a State of Emergency on February 29, 2020, I have issued seven (7) additional emergency orders mandating, among things: the closure of all K-12 public and private schools statewide; the prohibition of in-person classroom instruction at all public and private universities, colleges, technical schools, and apprenticeship programs; the prohibition of certain activities at nursing homes and assisted living facilities, as well as additional precautions that must be taken to protect these vulnerable populations; and the gathering of certain large groups of persons statewide. I anticipate the need to take additional emergency action on a broad range of issues within 24 to 48 hours.

The situation in Washington, and across the nation, has only grown more serious since I issued my Proclamation. As a result, I issued updated Proclamations on March 10<sup>2</sup> and March 11<sup>3</sup>, announcing further steps to protect our citizens and contain the outbreak. The virus does not respect geographical boundaries or distinguish between Federal and State authorities. The need for additional prompt action is clear.

I am submitting these waiver requests on behalf of the Health Care Authority (HCA), which is the single State agency for purposes of the Medicaid program in Washington. My office and HCA have worked closely with other affected State agencies in drafting these requests, including the Department of Health and the Department of Social and Health Services. In addition, we have incorporated requests from stakeholders such as the Washington State Hospital Association, who are working closely with State agencies to address this public health emergency.

Please contact us immediately if you need any additional information. Thank you for your prompt attention to this critical matter.

Sincerely,



Jay Inslee  
Governor

Enclosure(s)

cc: Susan E. Birch, Director, Health Care Authority  
MaryAnne Lindeblad, Medicaid Director, Health Care Authority  
John Wiesman, Secretary, Department of Health  
Cheryl Strange, Secretary, Department of Social and Health Services  
Calder Lynch, Director, Center for Medicaid and CHIP Services

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<sup>2</sup> [https://www.governor.wa.gov/sites/default/files/proclamations/20-06%20Coronavirus%20%28tmp%29.pdf?utm\\_medium=email&utm\\_source=govdelivery](https://www.governor.wa.gov/sites/default/files/proclamations/20-06%20Coronavirus%20%28tmp%29.pdf?utm_medium=email&utm_source=govdelivery)

<sup>3</sup> <https://www.governor.wa.gov/sites/default/files/20-07%20Coronavirus%20%28tmp%29.pdf>

**Provider Name/Type: All Washington State Medicaid, Medicare, Providers and Health Systems**

Contact person and information: MaryAnne Lindeblad, Medicaid Director

Email to CMS Regional Office: Jackie.glaze@cms.hhs.gov

This is a request for blanket waivers under Section 1135, including but not limited to those specified by CMS in its announcement of blanket waivers dated March 13, 2020, for the Medicaid program more broadly and all affected patients and providers in Washington State, in response to the COVID-19 pandemic. The state may submit additional requests based on individual provider changes and unique circumstances. The expected duration of the waiver is until the national public health emergency terminates.

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## 1 Brief summary of why the waiver is needed:

- 1.1 **Background.** On January 31, 2020, as a result of confirmed cases of 2019 Novel Coronavirus, Secretary of Health and Human Services, Alex M. Azar II determined a nationwide public health emergency exists.<sup>1</sup>
- 1.2 On February 29, 2020, Washington State Governor Jay Inslee declared a state-wide State of Emergency due to the outbreak in Washington State of COVID-19, the illness caused by the SARS-CoV2 virus. Governor Inslee directed state agencies and departments to do everything reasonably possible to assist affected political subdivisions in an effort to respond to and recover from the outbreak. On March 13, 2020, the President declared a national emergency under the Stafford Act, which allows, among other things the opportunity for CMS to waive requirements under Medicare, Medicaid, and CHIP, and CMS announced the availability of multiple blanket waivers, as well as the process for requesting additional flexibilities.
- 1.3 Washington State is at the epicenter of COVID-19 outbreak in the U.S., and in conjunction with New York now has the highest number of confirmed cases. As of March 14, 2020, the Department of Health reports that there have been 642 confirmed cases of COVID-19 in Washington State and 40 deaths from the disease. Community transmission of COVID-19 is occurring. Surveillance data suggest that the number of COVID-19 cases in Washington State will continue to significantly increase for an undetermined period of time.
- 1.4 At this time many providers in the state have opened or are working to open alternative care sites, and the Department of Health is urging hospitals to increase beds beyond their licensed bed capacity or to house patients in units that do not meet licensing standards.
- 1.5 A number of other providers are in voluntarily and mandatory quarantine. Long term care providers have been most hard hit, with the vast majority of the deaths in the U.S. occurring from residents in Washington nursing homes.
- 1.6 Subsequent to my initial declaration of a State of Emergency on February 29, 2020, I have issued seven (7) additional emergency orders mandating, among things: the closure of all K-12 public and private schools statewide; the prohibition of in-person classroom instruction at all public and private universities, colleges, technical schools, and apprenticeship programs; the prohibition of certain activities at nursing homes and assisted living facilities, as well as additional precautions that must be taken to protect these vulnerable populations; and the gathering of certain large groups of persons statewide. The state anticipates the need to take additional emergency action on a broad range of issues within 24 to 48 hours. This request is supported by Governor Inslee, the Washington State Health Care Authority, Department of Social and Health Services, Department of Health and providers throughout the states.

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<sup>1</sup> Secretary Azar subsequently issued a declaration under the Public Readiness and Emergency Preparedness Act for medical countermeasures against COVID-19, effective February 4, 2020.

- 1.7 Taking immediate steps to stem the spread of the pandemic in Washington is so urgent that the state has worked collectively with state agencies, counties and public health departments, providers and hospitals on this consolidated waiver request as a means to expedite approval. We have also worked with many other providers and the Medicaid managed care plans. Although we understand that the Secretary takes into account the number and volume of provider requests for waivers that a CMS Regional Office receives when determining the need for and geographic scope of an 1135 Waiver, the state intends to coordinate and consolidate our requests to the extent possible.
- 1.8 The health care delivery system is currently experiencing severe stress as a result of the COVID-19 outbreak in Washington, including in the areas of staffing, supplies, space and equipment:
- 1.9 **Staffing:** Health care providers report that:
  - 1.9.1 **Increased Volume:** The COVID-19 outbreak, and the predictable fears of residents that they may have COVID-19, have caused a major increase in the volume of Emergency Room and clinic visits, significantly longer ER wait times, the creation of new clinics and screening sites to handle potential COVID-19 patients, an increase in intensive care and inpatient hospitalizations, and difficulty in discharging hospital inpatients to lower-acuity sites of care, all resulting in a demand for additional clinical care providers and support staff; current staff are already working overtime and additional shifts to the maximum extent possible consistent with safe patient care;
  - 1.9.2 **Staff Quarantine:** Due to the sudden onset of COVID-19 cases, and based on the recommendations of the U.S. Centers for Disease Control and Prevention, a significant number of clinical care providers and support staff are currently quarantined until it can be determined whether they will develop the disease, resulting in additional staff shortages to deal with the increased volume of patients;
  - 1.9.3 **Available On-Call Staff:** Health care providers have attempted to obtain additional clinical care staff from their on-call pool of employees and from staffing agencies providing temporary workers; these sources have been insufficient to meet the demand based on patient volumes;
  - 1.9.4 **Staff Lack of Availability:** Many clinical care providers have school-age children or older family members who require supportive care; school closures due to COVID-19, the closure of senior centers and the relocation of adults from nursing homes and other residential facilities to reduce their risk of developing the disease, have caused these clinical care providers to stay home to care for their families, resulting in additional staff shortages to deal with the increased volume of patients.

- 1.9.5 Behavioral health providers: Many behavioral health providers, including Tribal health members, rely on face-to-face visits for counseling and substance use disorder treatment; however, with increased quarantine needed, patients and providers are increasingly finding it difficult to provide these services. The state continues to work on telephonic and telehealth options, but additional flexibility may be necessary as the situation changes.
- 1.10 **Supplies – Health care providers report that:**
- 1.10.1 Health care providers are currently experiencing a critical shortage of supplies, including personal protective equipment (PPE) such as masks, eye protection, N-95 respirators, powered air purifying respirators (PAPRs), gloves, and gowns. Regional and national stockpiles of PPE appear to be insufficient to meet the expected demand. Washington’s Department of Health has indicated that even with assistance from the Strategic National Stockpile, shortages continue to be a statewide (and national) problem. Many items of PPE are primarily manufactured in China, and production there is not expected to meet demand given the worldwide spread of COVID-19 and the drastically reduced production from Chinese factories;
- 1.10.2 In addition, due in part to PPE shortages and impacts on the ability to compound drugs, certain medications are already or may become in short supply; these include medications used to treat COVID-19 patients, as well as medications used by individuals with co-morbid conditions that put them at increased risk for developing COVID-19, as a result of which it is anticipated that additional cases of COVID-19 will occur due to these medication shortages;
- 1.10.3 Blood supplies throughout Washington State are critically low;
- 1.10.4 Testing kits and testing medium remain in short supply even as testing capacity at state and private labs has increased.
- 1.11 **Facilities:** Washington State ranks as one of the lowest states in the nation for number of hospital inpatient beds per capita. Washington state hospitals, including Critical Access Hospitals routinely experience challenges with limited bed capacity even during a typical influenza season. The high volume of patients and the need to separate potentially infectious COVID-19 patients from other patients in Emergency Room and clinic waiting and treatment areas has exceeded the physical space limitations of some health care providers. Currently, urban hospital beds are at or near full capacity due to COVID-19 response, increasing the need to transfer patients to other facilities, including Critical Access Hospitals. Some nursing homes are requiring a negative COVID-19 test prior to accepting patients for transfer or due to COVID-19 outbreaks are unable to accept patients, increasing overall state demand for inpatient hospital beds.

- 1.12 **Equipment:** The increased volume of COVID-19 patients has caused a shortage of equipment needed to treat them, which is expected to worsen as the number of COVID-19 patients increases. In particular, ventilators are in short supply; health care providers report that they anticipate exhausting all existing sources of supply, and no additional ventilators are available at this time. It is not known when or if additional ventilators will become available.

## **2 Consideration of the type of relief and reference to regulatory requirement:**

- 2.1 **Blanket Waivers.** (1) Washington is implementing all of the blanket waivers announced by CMS on March 13 in Medicaid and CHIP, to the extent applicable; (2) WA licensed providers authority will operate under all CMS blanket waivers announced by CMS on March 13; (3) Washington state is seeking additional blanket waivers articulated below, under which “all CMS licensed providers will operate upon CMS approval.”
- 2.2 **Additional Blanket Waiver Flexibility Requested.** In addition to the above waivers, Washington State is requesting blanket waivers as described herein.
- 2.3 **Emergency Medical Treatment and Active Labor Act.** Suspend enforcement of section 1867 of the Social Security Act (the Emergency Medical Treatment and Active Labor Act, or EMTALA). This will allow hospitals to screen or triage patients at a location offsite from the hospital’s campus and transfer patients according to protocols that account for COVID-19 status, not just according to existing transfer requirements.
- 2.4 **Institutions of Mental Disease (IMD).** 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.

## **3 Medicaid and Medicare Hospital Conditions of Participation (CoPs) and similar requirements –the state requests blanket waivers to the following:**

- 3.1 **Discharge Planning.** 42 C.F.R. §482.43(a)(8), 485.642(a)(8) Hospitals can discharge patients who no longer need acute care based solely upon which post-acute providers that can accept them without sharing the data requested by the regulators. Allowing for discharges in an efficient manner will free beds for acutely ill patients.
- 3.2 **Facilities and Make-shift clinic and Physical Environment** (42 C.F.R. §482.41; A-0700 et seq):
- 3.2.1 Non-hospital buildings/space can be used for patient care, provided sufficient safety and comfort is provided for patients and staff. This is another measure that will free up inpatient care beds for the most acute patients while providing beds for those still in need of care. It will also promote appropriate cohorting of COVID-19 patients.
- 3.2.2 These shall include make-shift locations for clinical and mandatory and voluntary quarantine sites awaiting test results. We must reinforce the existing shelter system by informing, resupplying and deintensifying existing shelters – these facilities may offer clinical services that should be paid for under CMS.

- 3.2.3 Create a new isolation and quarantine system to provide safe places for people who cannot quarantine at home.
- 3.2.4 Create emergency congregate assessment center/recovery facilities to slow the spread.
- 3.2.5 Approve the use of technology and physical barriers that limit exposure and potential spread of the virus, such as use of video and audio resources for limiting direct contact between physicians and other providers in the same clinical facility.
- 3.2.6 Permit treatment to occur in patient vehicles, assuming patient safety and comfort. Many facilities are standing up drive through specimen collection sites, we'd like to request basic evaluation and treatment be allowed in patient vehicles in order to prevent potential spread of the virus to the facility.
- 3.3 **Patient Rights.** 42 C.F.R. §482.13. Waive enforcement of patient rights related to personal privacy, confidentiality (see HIPAA request below), orders for seclusion, and patient visitation rights. This is necessary because hospitals may be required to undertake public emergency responses that make compliance with those CoP requirements impossible.
- 3.4 **Sterile Compounding.** 42 C.F.R. §482.25(b)(1) and USP 797 Face masks can be removed and retained in the compounding area to be re-donned and reused during the same work shift only. This will conserve scarce face mask supplies which will help with the impending shortage of medications.
- 3.5 **Verbal Orders** §482.24, A-0407, A-0454, A-0457 Verbal orders may be used more than 'infrequently' (read-back verification is done) and authentication may occur later than 48 hours. This will allow for more efficient treatment of patients in a surge situation.
- 3.6 **Reporting Requirements.** 42 C.F.R. §482.13(g) (1)(i)-(ii), A-0214 ICU patients whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs may be reported later than close of business next business day, provided any death where restraint may have contributed is continued to be reported within standard time limits. This is necessary because hospital reporting may be delayed due to increased care demands. Eliminating penalties keeps the focus on urgent patient care.
- 3.7 **Medical Staff.** 42 C.F.R. §482.22(a); A-0341 So that physicians whose privileges will expire and new physicians can practice before full medical staff/governing body review and approval. This will keep clinicians on the front line and allow hospitals and health systems to prioritize patient care needs during the emergency.
- 3.8 **Medical Records Timing.** 42 C.F.R. §482.24; A-0469 Medical records can be fully completed later than 30 days following discharge. This flexibility will allow clinicians to focus on the care needs at hand and deal with paperwork later.

- 3.9 **Physician referral.** Waive sanctions under section 1877(g) of the Social Security Act (relating to limitations on physician referral). This will allow hospitals to compensate physicians for unexpected or burdensome work demands (e.g., hazard pay), encourage multi-state systems to recruit additional practitioners from out-of-state, and eliminate a barrier to efficient placement of patients in care settings.
- 3.10 **Home Health** 42 C.F.R. § 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.
- 3.11 **Delivery of Services in Alternate Clinic Locations.** Waiver/flexibility 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 from alternative physical settings, such as a mobile clinic or temporary location. This will allow flexibility in site of clinics to promote appropriate infection control.
- 3.12 **Flexibility for Teaching Hospitals.** Allow flexibility in how the teaching physician is present with the patient and resident. Medicare generally requires that the physician be physically present in the room/area to bill as the teaching physician. With hospitals running low on supplies they are limiting the number of providers with direct patient contact. If hospitals allow real-time audio video or access through a window for the teaching physician, or otherwise distance the interaction should be covered.
- 3.13 **Flexibility in Patient Self Determination Act Requirements.** 42 USC 1396a(a)(54), and 42 USC 1395cc(a)(1)(57), (w), 42 CFR 489.102, Hospitals are required to provide information about policies to patients "upon admission." This is usually accomplished by the bedside nurse. Allowing flexibility in meeting these requirements will allow staff to more efficiently deliver care to a larger number of patients. This would not apply to the requirement hospitals inquire about the presence of an advance directive.

**4 Skilled Nursing Facility/Nursing Facility (SNF/NF) Conditions of Participation (COP) - The SNF/NFs are requesting blanket waivers to the following CoPs:**

- 4.1 Provider participation, billing requirements and conditions for payment – Waiver/flexibility to allow receiving facilities or alternate settings to receive SNF/NF or ICF/IID payment if a client is moved to a specialty facility to receive care and recover from COVID-19 during the COVID-19 crisis.
- 4.2 Opening a COVID 19 Facility:

- 4.2.1 Physical Environment. - 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.
- 4.2.2 Expedite certification process and expedite approval process from the Medicare Administrative Contractor (MAC)
- 4.2.3 Expedite Life Safety Code Process
- 4.3 Waiver of certain conditions of participation and certification requirements for opening a nursing facility if the state determines there is a need to quickly stand up a temporary COVID-19 facility.
- 4.4 Resident Groups - 42 CFR 483.10(f)(5) Residents have the right to organize and participate in resident groups – Given the Governor Proclamation 20-06 (attached) that encourages social distancing and requests facilities limit group activities within the resident population, Washington State SNF/NFs will not be able to meet the Resident Council requirements during this crisis.
- 4.5 Training and Certification of Nurse Aids - 42 CFR 483.35(d) indicates that a person is not to work in a nursing facility as a nurse aid unless they have completed a training and competency program. An individual may work as a registered nurse aid for up to 4 months if they are currently in a training program and complete the training program and the test within that 4 month period. We are requesting an exemption to the 4 month rule and to the full training requirements. Due to an already existing workforce shortage and multiple staff illnesses related to COVID-19 and influenza, along with testing sites and training sites temporarily closing to encourage social distancing and limit gathering of people in response to recommendations in Washington State Governor Proclamation 20-07, facilities are unable to fill critical Nurse aid positions with staff who have completed training and testing.

**5 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)– The ICF/IIDs are requesting blanket waivers to the following CoPs:**

- 5.1 Provider participation, billing requirements and conditions for payment – 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 COVID-19 during the COVID-19 crisis.

- 5.2 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.
- 5.3 Authorize facilities to adjust staffing patterns if doing so is necessary for staff to meet residents' basic health and safety needs
- 5.4 Authorize facilities to suspend community outings.
- 5.5 Authorize facilities to implement social distancing precautions to prevent individuals who are not directly involved in client care from entering the property.
- 5.6 Authorize facilities to suspend assessment and documentation requirements that are not necessary to maintain the residents' basic health and safety.
- 5.7 Suspend mandatory training requirements
- 5.8 Suspend all requirements related to the specially constituted committees.
- 5.9 Authorize the facility to implement social distancing precautions with respect to on and off-campus movement,
- 5.10 Suspend specialized services to prevent facility vendors from becoming disease vectors.
- 5.11 Authorize facilities to reschedule routine or elective medical and dental appointments
- 5.12 Suspend requirement facilities The facility must not house 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.
- 5.13 Authorize facilities to suspend adult training programs and active treatment to meet health and safety needs.
- 5.14 Suspend assessment or habilitation plan requirements including need for signatures.
- 5.15 Implement social distancing precautions with respect to on and off-campus movement.
- 5.16 Suspend Specialized services
- 5.17 Reschedule routine or elective medical, dental, or behavioral health appointments.
- 5.18 Conduct resident medical, dental, or behavioral health appointments via telehealth when available.

## 6 HIPAA Regulations waiver requests:

- 6.1 HIPAA Privacy. Pursuant to Section 1135(b)(7) of the Social Security Act, waive sanctions and penalties arising from noncompliance with certain HIPAA privacy regulations, including : 1) obtaining a patient's agreement to speak with family or friends or honoring a patient's request to opt out of the facility directory; 2) distributing a notice of privacy practices; or 3) the patient's right to request confidential communications.

- 6.2 HIPAA Security Requirements. 45 C.F.R. 164.312(e)(1) – Transmission Security; Waive the security requirements for video communication in a telehealth visit. While CMS has lifted many of the patient site requirements to allow telehealth in the home as well as non-rural areas, many facilities are not prepared with secure platforms that they own and control which are also accessible to the patient. The request is to allow providers to use readily available platforms like Facetime, WhatsApp, Skype, etc. to facilitate the telehealth visit with the patient at home.
- 6.3 Code sets. Request to waive HIPAA EDI code set requirements 45 CFR Part 162.1002. This would allow Washington 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 Washington to track and set rates for services specific to COVID-19.

## **7 Telehealth 42 C.F.R. §410.78(b):**

- 7.1 Consistent with the authority granted the Secretary under the *Coronavirus Preparedness and Response Supplemental Appropriations Act*, eliminate Medicare restrictions on licensing for telehealth and geographic restrictions on originating sites. Allow billing using CPT codes 99444 and 98969 for both new and established patients. Ask the HHS OIG to confirm that telemedicine screenings without co-pays and deductibles do not violate the CMP law or anti-kickback statute.
- 7.2 Eliminate the requirement that in order to bill for a telehealth service a provider must have billed that Medicaid or Medicare enrollee for a service within the previous three years.
- 7.3 Allow E&M codes to be billed via telehealth or telephonic services even for first time patients.
- 7.4 These steps will allow providers to screen and treat significantly more patients, reduce risk to front line health care providers, and assist in resolving the shortage of providers.
- 7.5 Allow for reimbursement for telephone visits at the same rate as telehealth video visits. For many cases the video aspect does not add value to the patient interaction – it’s the information relayed to the patient that matters. See CPT codes 99441, 99442, 99443; HCPCS G2012, G0071. The state believes we have authority to do this for telehealth and telephonic services under the Medicaid program, but this provision must be clarified for Medicare. In addition, consistent with our request above for the codes to be opened for new patients in addition to the established patients, which these codes currently only apply.
- 7.6 Allow capacity funding for providers, which may include grants or other funding Medicaid financing or other dollars available to be used for purchase of equipment as necessary for providers and patients (e.g. laptops, additional cell-phones or additional cell-phone plan minutes for clients so they are free to use the phone for services).
- 7.7 Provide indemnify/hold harmless for emergency telehealth services.

## **8 Medicaid/CHIP waiver requests:**

- 8.1 The state will also apply for the following emergency-related flexibilities authorized under federal regulation that do not require an amendment to the State Plan or Verification Plan. We note that some of these requests can be addressed otherwise. We will follow up with a concurrence letter to CMS.
- 8.2 The State of Washington operates eight waivers under 1915(c) authority. The state requests continued flexibility under the appendix k amendments submitted to CMCS March 12, 2020. The state also requests that as the situation changes and additional flexibilities are recognized as necessary for the health and safety of Washingtonians that CMCS review and approve flexibilities for the 1915(c) waivers.
- 8.3 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.
- 8.4 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.
- 8.5 Allow presumptive Medicaid eligibility for the Aged, Blind, and Disabled population.
- 8.6 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.
- 8.7 Extend redetermination timelines for current Medicaid enrollees in the state to maintain continuity of coverage as permissible under 42 CFR 435.912(e).
- 8.8 Waive Pre-Admission Screening and Annual Resident Review (PASSAR Level I and Level II Assessment. Level I screens are not required for residents who are being transferred between nursing facilities and staff cannot enter nursing homes due to quarantine. If the nursing facility is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake. If there is not enough information to complete a Level I, the nursing facility will document this in the case files. Level II evaluations and determinations are also not required preadmission when residents are being transferred between NFs. Residents who are transferred will receive a post admission review which will be completed as resources become available. (42 CFR 438.106(b)(4).

- 8.9 Waive requirements related to the post eligibility treatment of income which will enable affected beneficiaries to retain funds otherwise required to be collected and applied toward the cost of care. (42 CFR 435.217)
- 8.10 Waive requirement that Washington State must submit and receive CMS approval of a Title XIX or Title XX state plan amendment in order to temporarily waive any patient cost sharing associated with COVID-9 screening, testing, and treatment.
- 8.11 Waiver to permit distant site (provider) services to be rendered in a rural health clinic (RHC). Currently Medicare prohibits distant site telehealth to be rendered by a provider in a RHC. This limitation is not by regulation, but rather, sub regulatory guidance. RHCs have very limited resources and providers. For the RHC's protection and sustainability the state requests to have the telehealth prohibition lifted to allow RHC providers to render telehealth treatment in the RHC. This limitation is not contained in the RHC regulations at 42 CFR 491; rather it is contained in sub-regulatory guidance that first appeared in 2013. The Medicare Policy Manual, chapter 13, section 200. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.
- 8.12 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 C.F.R. Part 438, for 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. The state understands that this may require an 1115 waiver, in which in light of the emergency, the state requests that it would not have to meet transparency requirements.
- 8.13 We request allowing 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.
- 8.14 Tribal Health Systems: The state is interested in exploring any Tribal health related waivers that may be needed. American Indian and Alaskan Native members have unique problems. There are critical behavioral health services in which Tribal members experience a disproportionate worse outcomes. We must expedite funding.
- 8.15 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.
- 8.16 Fair Hearings and Notices – Section 1902(a)(3). To enable the State to extend fair hearing timeframes as needed.

- 8.17 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.
- 8.18 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.
- 8.19 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.
- 8.20 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.
- 8.21 Freedom of Choice - Section 1902(a)(23)(A). To enable the State to restrict freedom of choice of provider.
- 8.22 Provider Agreements and Direct Payment to Providers - 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 but have such an agreement with another State.
- 8.23 Annual Redeterminations of Eligibility – Sections 1902(a)(4) and 1902(a)(19). To permit delay of otherwise required redeterminations for the State’s XIX program.
- 8.24 Amount, Duration, and Scope – Section 1902(a)(10)(B). To the extent necessary to enable the state to offer different benefits to affected beneficiaries.
- 8.25 Cost and budget neutrality requirements 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.
- 8.26 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 [42 CFR 441(b)(1)(ii)].
- 8.27 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)
- 8.28 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
- 8.29 Requirements related to home and community-based settings in order to ensure the health, safety and welfare of affected beneficiaries [441.301(c)(4)].
- 8.30 Requirements for public notice as applicable to the authorities selected for this demonstration.

- 8.31 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.
- 8.32 Medicaid Administrative Claiming program: We are currently working with CMS on options, but we request authority to expand the match to other public health services not currently covered.
- 8.33 Waive signature requirements on level of care assessments, plans of care and other required supporting documentation.
- 8.34 Medicaid requests the same waivers for Medicare services as applicable generally and specifically for the telehealth provisions requested above.
- 8.35 We request enhanced eligibility levels for those uninsured under the crisis period who may be above the 135% to 200% FPL and lift the 5-year bar period.
- 8.36 Broadly waive any other face-to-face requirement.
- 8.37 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:
  - 8.37.1 Adjusting performance deadlines and timetables for required reporting and oversight activities;
  - 8.37.2 Modifying deadlines for CMS Outcome and Assessment Information Set (OASIS) and Minimum Data Set (MDS) assessments and transmission;
  - 8.37.3 Allow Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies;
  - 8.37.4 Temporarily delaying, modifying or suspending CMS-certified facilities' onsite survey, re-certification 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;
  - 8.37.5 Temporarily suspending 2-week aide supervision requirement by a registered nurse for home health agencies; and,
  - 8.37.6 Temporarily suspending the supervision of hospice aides by a registered nurse every 14 days requirement for hospice agencies.
- 8.38 Waive 42 CFR 170(4) requirements for Non-Emergency Medical Transportation (NEMT), which currently prohibits contracted transportation brokers from directly providing trips to Medicaid clients.
- 8.39 Temporarily waive Medicaid requirements related to hiring to ensure a sufficient number of providers are available to serve Medicaid enrollees.
- 8.40 Temporarily cease the revalidation of and waive provider renewal requirements during this state of emergency.

- 8.41 Temporarily waive requirements that out-of-state providers be licensed in Washington when they are licensed by another state Medicaid agency or by Medicare.
- 8.42 Allow facilities to provide services in alternative settings, such as a temporary shelter or through mobile-units. This may include potential relief from Drug Enforcement Administration (DEA) requirements around medications.
- 8.43 Temporarily expand eligibility to in-home services for an individual who does not meet functional eligibility, when a congregate site such as an adult day health center closes.
- 8.44 Home Health providers and others may need enhanced payment.

## **9 1115 Waiver and Accountable Communities of Health:**

- 9.1 We ask for immediate approval of our 1115 budget neutrality corrective action plan to ensure critical Accountable Communities of Health (ACH) and Delivery System Reform Incentive Payments (DSRIP) are stabilized during this time.
- 9.2 The provider community is quickly turning to the ACHs seeking help. We ask for the establishment of a regional COVID-19 response initiative to allow for Medicaid match to support emerging issues and necessary community efforts to mitigate provider burden, community distress, and misalignment across community response efforts. ACHs may serve as a regional response hub. As the hub, ACHs would not replace Local Health Jurisdictions. An ACH, rather, would coordinate across clinical and community partners, including community engagement, education, provider relief, and alignment of response strategies around emerging best practices across communities and Local Health Jurisdictions. This may include:
  - 9.2.1.1 Planning to assist providers to adjust to business effects and ensure development and implementation of sustainable business options and practices that ensure immediate and longer-term viability and ensure access throughout the emergency. This may also include revenue support for providers that must temporarily close for deep cleaning or staffing shortages.
  - 9.2.1.2 Assist providers to implement new activities by developing community-visit policies and guidance that align with the Washington State Department of Health. We ask that CMS allow HCA to determine the types of providers who are authorized for services; thus waiving traditional requirements like need for formal licensing or certification (e.g. Washington does not license Doulas or community health workers).

- 9.2.1.3 Assist providers in staying up-to-date on reimbursement exceptions and practices and other resources so that they may concentrate on providing services. Provide guidance regarding HIPAA/consent and telehealth/telephone encounters such as telehealth exceptions for providers providing medication for opioid use disorders who may also need assisting requesting additional days supplies. Support and develop protocols, policies, staffing, training, or staffing adjustments for residential treatment facilities to ensure safe treatment program and drop-in individuals admitted due to additional screening. Disseminate information from multiple payers and state agencies for providers to be able to quickly discern what is required of them and move forward to ensure they are meeting the minimum required to be reimbursed while ensuring their staff, and clients are treated quickly and safely.
- 9.2.2 Timely Filing Requirements for Billing. 42 CFR 424.44 Waiver of timely filing requirements that will allow providers getting correct coding and other structural pieces built into their systems and even payer ability to adjudicate.
- 9.2.3 Community-based care coordination:
  - 9.2.3.1 Focus community-based care coordination directly on COVID-19 activities by working with traditional and non-traditional providers such as community health workers to plan and perform community coordination and workforce improvements as needed.
  - 9.2.3.2 Perform services that ensure continuity of care for high-risk individuals.
  - 9.2.3.3 Permit community-based care coordination to expand its role to additional community activities such as meals on wheels; non-emergency transportation or support the transportation of providers or individuals to ensure the delivery of services; assistance to homeless individuals or greater diversion activities to help individuals retain their homes; delivery of food or clothing, or any other need identified by an Accountable Community of Health that assists individuals and the community with remaining healthy and safe while avoiding the need for more intensive medical and behavioral services.
- 9.2.4 Community convening and educating: continued community outreach and education to providers, organizations and individuals to provide accurate, up-to-date information and guidance on COVID-19. Continue to support community preparedness and promote safe practices that reinforce policies and guidance from the CDC and Washington State Department of Health. Package and provide training to all providers in the community on as additional guidance is released.
- 9.2.5 Permit requests for funds ahead of scheduled release of federal funding to address COVID-19 needs.

- 9.2.6 Allow payment of flexible services for ACHs and FCS providers to be able to assist an individual who's housing may be at risk. Also use the flexible funds to pay for phones for individuals to access BH services if telehealth is the primary method of service delivery. (MA 1115 waiver allows for payment of flexible services) <https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program#flexible-services-> (this could be added to section 6.12)
- 9.2.7 The FCS provider network under Initiative 3 of the 1115 waiver is in its infancy since implementation January 2018. The network is very vulnerable due to the Covid-19 crisis. Services are largely dependent upon face-to-face services with individuals, landlords and employers in the community. Significant investments in training of staff to implement the evidence-based practices and as such we are proposing increases in telephone service capacity as well as provider capacity payments for FCS providers to be able to be sustained through the covid-19 crisis. Many of these providers are small non-profit organizations that rely on the face-to-face delivery of services in order to sustain their workforce. With DOH guidelines many of these small non-profits are at risk. Propose significant investments of flexible service funding for participants enrolled in FCS services. (see MA guidance).

## **Conclusion**

The trajectory of the COVID-19 outbreak in Washington State is critical. We are concerned that the healthcare system may quickly become overwhelmed. Washington State providers and hospitals are struggling with ongoing shortages of staffing, supplies, and facilities, as more and more COVID-19 cases in the State are confirmed. A blanket waiver of the foregoing federal requirements is necessary to allow Washington's hospitals to properly focus their efforts on curtailing the spread of the pandemic.