March 23, 2020

Charles Friedrich
CMCS| Medicaid and CHIP Operations Group (MCOG) Office of the Regional Administrator
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Via email transmittal to Charles.Friedrich@cms.hhs.gov

Dear Mr. Friedrich,

On January 31, 2020, in anticipation of the effects of 2019 Novel Coronavirus (2019-nCoV), Secretary of Health and Human Services Alex Azar declared a public health emergency pursuant to Section 319 of the Public Health Services Act. On March 13, 2020, as authorized under Title V of the Stafford Act, President Donald J. Trump declared a national emergency in response to the effects of the 2019-nCoV. Also, on March 13, 2020, Secretary Azar issued his formal waiver approval authority under Section 1135.

Blanket Waiver

The North Carolina Healthcare Association, on behalf of North Carolina hospitals and health systems is respectfully requesting confirmation that its members may provide and seek reimbursement for care consistent with the waivers of certain federal Medicare, Medicaid, CHIP and HIPAA regulations as announced by CMS on March 13 and further requested by the State of North Carolina in its letter of March 17, 2020. (included in the attachment) without submission of Section 1135 requests by individual providers with respect to any of the items already waived as noted above. These waivers are necessary to ensure that sufficient resources are available to meet the needs of our state's residents as well as those of our providers and their patients and personnel. The North Carolina Healthcare Association expects its members and their personnel will operate under all CMS blanket waivers announced by CMS on March 13, 2020.

Additional Waiver Request

In addition, to the extent that the following exceed the scope of those previously issued blanket waivers, NCHA submits the following waiver requests on behalf of its members and effective as of the date of the above-mentioned declarations, to address situations that may be unique to North Carolina hospitals and health systems. Our intent is to utilize the HHS-authorized blanket waivers, but because we are still evaluating the impact of HHS-authorized blanket waiver authorities, and because of the quickly changing healthcare environment, we wanted to request the following as well as request your consideration of additional waivers in the future. The requested waivers below reflect patient and provider needs in current and anticipated situations where emergency departments and other units may be operating at capacity serving extremely contagious individuals in addition to the already-heavy volume of other acutely ill patients that cannot be served elsewhere in the current regulatory environment. These waivers will give North Carolina providers additional flexibility to implement reasonable changes, as needed, under present and anticipated emergency circumstances, to address the urgent health care needs of our residents, to ensure they are cared for in the most appropriate settings, and to further state and nation-wide efforts to protect patients and employees from exposure to COVID-19 pathogens.

Behavioral Health Patients

NCHA has identified additional needs and is requesting confirmation and/or issuance of the following waivers on behalf of its members due to the high volume of individuals with behavioral health needs presenting and being cared for in hospital emergency departments and inpatient psychiatric units. Current COVID-19 infection control requirements and the limited number of alternate care providers are intensifying the care situation for many individuals in need of behavioral health care.

- Waiver permitting acute care hospitals without a distinct part inpatient psychiatric unit or with a distinct part inpatient psychiatric unit that is at capacity to place involuntarily committed behavioral health patients into beds determined to be appropriate for care, even if they may not meet federal life safety requirements, for periods of greater than 24 hours. The request is due to capacity or other exigent circumstances related to the emergency.

- Waiver permitting hospitals in the above situation to bill for inpatient psychiatric services payment and to annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in a temporary setting because of capacity or other exigent circumstances related to the emergency.

- Waiver permitting acute care hospitals to transfer individuals who present to a hospital's dedicated emergency department or any other hospital department or facility with psychiatric/behavioral health symptoms or complaints only to alternate care sites to receive a medical screening evaluation, assessment, stabilization, and/or treatment because of capacity, capability, or other exigent circumstances related to the COVID-19 emergency. This will permit hospitals to free up capacity in their dedicated emergency departments and help to prevent behavioral health patients from being boarded and potentially exposed to COVID-19 in EDs.

- We request a North Carolina Medicaid waiver to enable the use of the state's 1115 waiver to reimburse providers for psychiatric care provided to patients.

Health Insurance Portability and Accountability Act
NCHA requests the following waivers and flexibilities to enable hospitals to be more flexible and efficient in providing appropriate screening, diagnosis, and placement, and to protect patients and employees from exposure to COVID-19 pathogens.

- We request an extension of the 72-hour duration period of the 1135 waiver to 60 days under the authority of 42 USC §1320b-5(e)

- We request that the limited waiver for HIPAA Sanctions be expanded to include a waiver of sanctions for failure to comply with the verification requirements of 45 CFR §164.514(h) such that covered entities may rely in good faith upon the verbal representations of the person requesting the PHI about their relationship with the patient.

- We request that the limited waiver for HIPAA Sanctions be clarified to note that in the event of a presumptive positive or positive diagnosis of COVID-19, the covered entity may notify the patient's employer of the need for quarantine in the covered entity's discretion, regardless of whether the covered entity meets the requirements of 45 CFR §164.512(b)(v).

- We request that the limited waiver for HIPAA Sanctions be expanded to allow covered entities to share PHI about patients who are likely to seek services from both entities due to their overlapping service areas, but with whom each covered entity may not yet have a relationship

with the patient for purposes of treatment or health care operations (including communicable disease preparations) under 45 CFR §164.502(c).

- We request that the limited waiver for HIPAA Sanctions be clarified to state that community shelters, such as homeless shelters and half way houses, be included in the definition of health care provider in cases where shelter staff need to know about a patient's positive or presumptive positive COVID-19 diagnosis in order to follow proper care and quarantine measures. In such cases, the covered entity may share relevant PHI with such shelters as part of the patient's treatment and care coordination.

Outpatient Services/Telehealth

NCHA is requesting confirmation and/or issuance of the following waivers to ensure that patients can access services in locations that are consistent with efforts to protect patients and employees from exposure to COVID-19 pathogens, to enable effective use of scarce healthcare personnel and to mitigate the potential need for hospital-based crisis services.

- Waivers to eliminate Medicare requirements for signed treatment/consent for admission (COT/COA) documents for telehealth and telephonic treatment.

- Waivers to permit Medicare and Medicaid payment for telehealth services, using CPT codes 99444 and 98969 for both new and established patients.

- Waiver of any Stark, anti-kickback and beneficiary inducement regulations and confirmation that the provision of telemedicine encounters without co-pays and deductibles does not violate the CMP law or anti-kickback statute.

- Waiver of all Medicare and Medicaid payment restrictions for the provision of *enhanced outpatient services* for behavioral health via telemedicine.

- Waiver to eliminate Medicare restrictions on the use of telehealth for group therapy settings.

- Waiver to eliminate Medicare and Medicaid restrictions on telehealth services when provided by a provisionally and fully Licensed Clinical Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker or Licensed Clinical Addiction Specialist.

- Waiver to permit streamlined credentialing processes for all telehealth clinicians.

- Waiver of face-to-face care provision requirements under NC Medicaid *Enhanced Service Definitions* and to permit telehealth and telephonic consult by Associate Professionals, Qualified Professionals, Licensed Professionals and Associate Licensed Professionals for all components of NC Medicaid *Enhanced Services*. This would allow assertive community treatment team, community support team, intensive in-home services, Peer Support, and other enhanced benefit teams to immediately engage existing and new patients virtually while social distancing advisories are in effect.

Alternate Care Provisions

NCHA is requesting the following waivers to expedite care during likely periods of patient surge, to enable effective use of scarce healthcare personnel, and to ensure the efficient administration and proper reimbursement of providers for alternate site care and telehealth.

- Waiver/flexibility to allow hospitals to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings such as a remote emergency room, alternate clinic site, mobile clinic or temporary location. This will allow flexibility in site of clinics to promote appropriate infection control.

- We request a waiver of pre-certification or prior authorization requirements for Medicare Advantage fee-for-service programs and a waiver of the out-of-network requirements for non-elective services.

- We request a waiver permitting billing and reimbursement for physician assistants, nurse practitioners and other non-physician advanced practice/allied health providers without requiring an attestation by the supervising physician.

- We request a waiver of the requirements of 42 C.F.R. 424.516(b), (c), (d) and (e) regarding the timely reporting of changes of information, including but not limited to new practice locations.

- To enable health system medical staff offices and medical staff leadership to focus on disaster privileging and other pandemic related medical care, NCHA requests a waiver from CMS of §482.22(a)(1) which requires that reappointments be conducted at least every 24 months.

- To the extent locations are temporary sites of a hospital (whether on-campus or off-campus) or of a non-hospital physician practice set up to test or treat patients as a consequence of the COVID-19 crisis, we request CMS waive any requirement that such locations be reported on the hospital or physician practice enrollment record. We further request CMS waive any requirements necessary so that, for temporary locations of a hospital or non-hospital physician practice, the services provided at the temporary site will be deemed to have been provided in the hospital location or physician practice location, as applicable, closest to the temporary site, and will be billed accordingly. "Temporary" for these purposes means any location – whether in a brick and mortar building or alternative site, such as a tent - that is established during the public health emergency until such time as the applicable hospital or physician practice determines it is no longer needed.

- Further, as to physicians and non-physician practitioners (collectively, "Practitioners") that provide telehealth services, virtual check-ins/visits, and e-visit/digital evaluation and management services from home, we request CMS waive any requirement that the Practitioner's home address be reported as a location on the Medicare enrollment record of the practice to which he/she has reassigned his/her billing privileges and that such services be deemed to have been provided at the practice location where the Practitioner usually practices and be billed accordingly. Further, as to non-physician practitioners who only provide services from home, we request CMS waive any requirement necessary so that the services will be deemed to have been provided at the usual practice location of the non-physician practitioner's supervising physician.

- We request a waiver be issued providing for the temporary suspension of Medicare contractor requirements regarding medical review and some benefit integrity responsibilities. This includes the following:
    - Assurances that future retrospective denials based on inappropriate place of service will take into account the period of time and circumstances when the disaster occurred;
    - Assurances that future medical review audits and denials will take into account the period of time and circumstances when the disaster occurred;

- Assurances that Medicare's two-day payment policy used in determining whether an inpatient admission is reasonable and payable under Medicare Part A will take into account the period of time and circumstances when the disaster occurred;
- A delay in requests by Medicare contractors (e.g. MACs, RACs, ZPICs, CERTs) for additional documentation requests/medical records from hospitals;
- A delay in the amount of time a hospital has to appeal audit findings;
- A delay in any hearings to challenge Recovery Audit Contractor determinations; and
- A delay in the 30-day period before the Recovery Audit Contractor sends the results of their audit to the Medicare Administrative Contractor for recoupment. We are not requesting a lapse of enforcement for actions relating to fraud and abuse.

Other Acute Services

- We request a waiver permitting acute care hospitals to house acute care inpatients in acute care rehabilitation or psychiatric hospitals under common ownership and where the beds are appropriate for acute inpatient care but may not meet federal life safety requirements.

- We request a waiver of the requirement that inpatient rehabilitation units and hospitals provide three or more hours of therapy to patients in the above situations.

Post-Acute Care

NCHA requests waivers to protect patients and employees from exposure to COVID-19 pathogens and to ease the administrative burden on providers of home care services.

- In addition to the (attached) waiver request of the skilled nursing facility (SNF) 3-day rule, we request a waiver of the Medicare Outpatient Observation Notice (MOON) written and oral notification requirements.

- We request that the All-Inclusive Care for the Elderly, a.k.a. PACE requirements temporarily waive timelines associated with Service Delivery Requests, Appeals and Grievances, to permit a delay in enrollment, assessment and care plan timelines, to permit PACE staff to provide home care services and to provide flexibility in using telephonic means to conduct assessments as appropriate.

Post-Acute Care/Hospice

- Because of the potential for compromised access to patients in their location of care, we request a waiver to permit additional flexibility on the 48 hour timeframe for the initial assessment for hospice services, for additional flexibility on the 5 day timeframe the comprehensive assessment, for additional flexibility on the timeframes for the review of the plan of care and for additional flexibility on scheduled updates for assessments.

- Because of the potential for diminished availability of employed care staff and volunteers, we request a waiver to permit the use of contracted personnel for nursing, social work, spiritual care counseling, bereavement counseling, dietary counseling, and a waiver providing flexibility in the requirement that volunteers provide 5% of patient care hours of all paid hospice employees and contract staff.

- Because of the potential for diminished availability of employed care staff and supervisors, we request a request a waiver of the 2-week aide supervision requirement.

- Because of the potential for compromised access to patients in their location of care, we request a waiver to permit use of telehealth to meet face to face requirements for delivery of hospice services.

- We request that CMS redefine continuous care regulations to facilitate care of COVID19 patients who may otherwise not qualify for needed home-based services.

Post-Acute Care/Home Care
NCHA requests waivers to permit the use of telehealth and other remote patient care tools in accordance with efforts to protect patients and employees from exposure to COVID-19 pathogens and to ease the administrative burden on providers of home care services.

- We request a waiver to permit telephonic visits to be part of the clinical record for the home health episode in lieu of in-person visits for nursing and rehab disciplines.

- We request a waiver to permit video visits in lieu of in person visits for all nursing and rehab disciplines.

- We request a waiver to permit remote patient monitoring of patients screened positive for COVID-19 and to enable coordination with physician providers with provision for payment.

- We request a waiver of the face-to-face requirement for community referrals if the patient is unable to be seen by their physician or a non-physician practitioner.

- We request a waiver of the homebound requirement and a suspension of the Patient-Driven Groupings Model's (PDGM) unacceptable diagnoses so high-risk patients can be treated at home to avoid emergency room visits and avoidable hospitalizations.

- We request a suspension of the in-home requirement for supervision of home health aides and therapy assistants

- We request a waiver to permit certifications and assessments along with home bound status determination be completed remotely or by record review.

- We request a waiver of prior authorization requirements for post-acute care placement to enable hospitals to free up inpatient bed capacity.

Home Infusion:
NCHA requests waivers in accordance with provider efforts to protect patients and employees from exposure to COVID-19 pathogens.

- We request a waiver to permit the delivery of medications & supplies without patient signature but with visual or verbal confirmation documented in the record.

- We request a waiver to expand the quantity dispensed of part B enteral nutrition supplements and supplies.

Home DMEPOS (Durable Medical Equipment Prosthetic Orthotic Suppliers)
NCHA requests waivers in accordance with provider efforts to protect patients and employees from exposure to COVID-19 pathogens and to ensure the most effective use of scarce staff resources.

- We request a waiver to permit the delivery of equipment and supplies without patient signature, but with visual or verbal confirmation documented in the record.

- We request a waiver of Regulatory relief from any face-to-face requirements for equipment such as oxygen and pap or allow for telehealth using telephone or video options.

- We request a waiver of sleep study and/or titration for pap set-up as long as pap machine has auto-titration capabilities.

- We request a waiver of the chronic stable state requirement for home oxygen services.

- We request a waiver of previous treatments tried and failed for oxygen qualifying order as long as qualifying test was performed.

NCHA appreciates your implementation of the blanket waiver provisions and your consideration of our supplemental requested waivers that may be beyond the scope of those blanket waiver provisions. Moving forward we also request that CMS consider that additional provisions, perhaps beyond the scope of the existing waiver, might become necessary. For example, CMS should consider establishing a regulatory framework that would permit use of Skilled Nursing Facility sites to provide acute care services where appropriate, in the event additional capacity is needed.

We thank you for your approval of waivers of Federal Medicaid, Medicare, CHIP and HIPAA requirements necessary for North Carolina Hospitals to most effectively care for residents and patients in response to the COVID-19 pandemic.

If you have any questions, please contact me (slawler@ncha.org, 252-258-5228) or Cody Hand, Senior Vice President (chand@ncha.org, 919-793-8318) or Mike Vicario, Vice President of Regulatory Affairs (mvicario@ncha.org, 919-491-5898).

Sincerely,

Stephen J. Lawler
President and CEO
North Carolina Healthcare Association

Attachments

c: Dave Richard, NC DHHS

Attachment 1 of 1

On behalf of North Carolina Hospitals and Health Systems, The North Carolina Healthcare Association is seeking to apply approved 1135 waivers listed below (as authorized under March 13, 2020 CMS Guidance and Secretary Azar's March 13, 2020 Declaration), as well as flexibilities and additional waiver authorities requested by the State of North Carolina in its written request of March 17, 2020 and included below.

- **Waive the Critical Access Hospital (CAH) limit of beds to 25 and length of stay 96 hours.** North Carolina is requesting a blanket waiver for this authority;

- **Waive certain provider screening and enrollment requirements.**
  - Temporarily waiving payment of application fee to temporarily enroll a provider;
  - Temporarily waiving criminal background checks to temporarily enroll a provider;
  - Temporarily waiving site visits to temporarily enroll a provider;
  - Temporarily ceasing revalidation of providers who are enrolled with NC Medicaid or otherwise directly impacted by the emergency;
  - Temporarily waiving requirement that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another state or enrolled with Medicare;
  - Temporarily suspending pending enforcement or termination action or denial of payment sanction to a specific provider;
  - Providing payments to facilities for providing services in alternative settings, including an unlicensed or temporary facility, if the provider's licensed facility has been evacuated, compromised, is inadequate to meet the demand as determined by the state or the facility or is necessary to protect the health and safety of other patients; and,
  - Establishing a toll-free hotline for non-certified Part B suppliers, physicians and nonphysician practitioners to enroll and receive temporary Medicare billing privileges.

- **Waive certain hospital regulatory requirements**.
  - Allowing acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute inpatient care but may not meet federal life safety requirements;
  - Allowing acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric units to acute care beds and units if required as a result of the emergency;
  - Allowing acute care hospitals with excluded distinct part inpatient rehabilitation units to relocate inpatients from the excluded distinct part rehabilitation units to acute care beds and units if required as a result of the emergency;
  - Allowing Inpatient Rehabilitation Facilities (IRFs) to exclude patients from the hospital's or 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;
  - Allowing a long-term care hospital (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;
  - Allowing Medicare Inpatient Prospective Payment System (IPPS) excluded inpatient psychiatric units and IRFs serving inpatients to access comprehensive payments without a CMS case-by-case review where the State has approved use of these locations;
  - Waive the following requests for Medicare appeals in Fee for Service, MA and Part D:
    - Extension to file an appeal;

- Waive timeliness for requests for additional information to adjudicate the appeal;
- Processing the appeal even with incomplete Appointment of Representation forms but communicating only to the beneficiary;
- Process requests for appeal that don't meet the required elements using information that is available; and,
- Utilizing all flexibilities available in the appeal process as if good cause requirements are satisfied.

- **Waive certain Health Insurance Portability and Accountability Act (HIPAA) requirements.** North Carolina is requesting blanket waiver authority to temporarily suspend the application of sanctions and penalties arising from non-compliance with HIPAA requirements related to the following (as authorized in Secretary Azar's March 13, 2020 declaration):
  - Obtaining a patient's agreement to speak with family members or friends (as authorized in Secretary Azar's March 13, 2020 declaration);
  - Honoring a request to opt out of the facility directory (as authorized in Secretary Azar's March 13, 2020 declaration);
  - Distributing a notice (as authorized in Secretary Azar's March 13, 2020 declaration);
  - The patient's right to request privacy restrictions (as authorized in Secretary Azar's March 13, 2020 declaration);
  - The patient's right to request confidential communications (as authorized in Secretary Azar's March 13, 2020 declaration); and
  - Enabling the State to temporarily allow the use of non-HIPAA compliant telehealth technologies (North Carolina is seeking to approval of this additional HIPAA waiver request to the list of approved waivers).

- **Waive certain Emergency Medical Treatment and Labor Act (EMTALA) requirements.** North Carolina is requesting blanket waiver authority to temporarily suspend application of EMTALA sanctions for redirection of an individual to receive a medical screening examination in an alternative location or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency (as authorized in Secretary Azar's March 13, 2020 declaration).

North Carolina is also seeking 1135 waiver approval from certain requirements as described in the August 20, 2018, CMS Disaster Relief Inventory and as authorized under March 13, 2020 CMS Guidance:

- **Waive certain reporting, oversight and fair hearing requirements.** North Carolina is requesting blanket waiver authority for the following (as described in the August 20, 2018, CMS Disaster Relief Inventory):
  - Adjusting performance deadlines and timetables for required reporting and oversight activities;
  - Suspending pre-admission screening and annual resident review (PASRR) Level I and Level II Assessments while the federal and state emergencies are in effect;
  - Modifying deadlines for CMS Outcome and Assessment Information Set (OASIS) and Minimum Data Set (MDS) assessments and transmission;
  - Allow Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies;
  - Temporarily delaying, modifying or suspending CMS-certified or tribal facilities' onsite survey, re-certification and revisit surveys conducted by the federal government or 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 or longer if the emergency extends beyond the federal fiscal year (North Carolina seeks to slightly modify the authority approval described in August 20, 2018 CMS Disaster Relief Inventory);

  - Temporarily suspending 2-week aide supervision requirement by a registered nurse for home health agencies;
  - Temporarily suspending the requirement of supervision of hospice aides by a registered nurse every 14 days for hospice agencies; and,
  - Allowing Medicaid/CHIP enrollees to have more than 90 days (eligibility or fee- for-service appeal) to request a state fair hearing.
  - Modify 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 zero days in accordance with the requirements specified below.
  - Extend timelines for more than 120 days for managed care enrollees to request a State Fair Hearing.

- **Waive certain benefit and authorization requirements.** (As described in March 13, 2020 CMS Guidance):
  - Waiving prior authorizations in Medicaid;
  - Extending minimum data set authorizations for nursing facility and Skilled Nursing Facility (SNF) residents;
  - Suspending the three-day hospitalization requirement prior to Medicare-covered admission to skilled nursing facilities;
  - Enabling certain beneficiaries who recently exhausted their SNF benefits to obtain renewed SNF coverage without first having to start a new benefit period; and,
  - Suspending replacement requirements for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) that are lost, destroyed, irreparably damaged, or otherwise rendered unusable, such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement.

We are seeking 1135 authority for the following flexibilities that were not articulated in recent CMS guidance and have not been previously approved in other states' 1135 waiver requests but are critical authorities to ensuring on-going access to health care items and services to respond to this public health crisis:

- Simplifying program administration by allowing for temporary state plan flexibilities, such as lifting benefit limits, cost sharing, applying targeted rate increases for certain provider types or specialties, rather than requiring states go through the SPA submission and approval process. State will memorialize the temporary State Plan changes in formal documentation submitted to CMS;
- Suspending SNF bed hold timelines for SNF residents that are temporarily moved home or who go into a hospital;
- Temporarily allowing non-emergency ambulance suppliers and non-enrolled NEMT providers to provide NEMT services;
- Enabling State to briefly shelter patients at non-certified/licensed facilities;
- Waiving timeliness requirements related to triaging complaints and investigation of complaints in CMS-certified facilities unless it involves immediate jeopardy complaints (cases that represent a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect or complaints alleging serious infection control concerns; when investigating a complaint related to an immediate jeopardy or infection control, personal protection equipment must be available for use by the surveyor/investigator;
- Allowing state to draw federal financing match (at regular FMAP rates) for payments, such as hardship or supplemental payments, to stabilize and retain providers of Behavioral Health/IDD, Long Term Care settings (including home care and community health workers), IHS Providers and Early Intervention providers who suffer extreme disruptions to their standard business model and/or revenue streams as a result of the public health emergency;

- Suspending required eligibility assessment for patients going from a SNF to home setting (or do assessment at sending entity; follow-up assessments or modifications can be done at a later date);
- Enabling hospitals that do not have either a hospital-based SNF or a swing bed unit to use their acute care beds to provide SNF level care;
- Allowing flexibility to cover housing-related services, including temporary housing, housing application assistance, and transfer/moving expenses, in order to safely discharge homeless individuals or those without a safe and an appropriate discharge location; and,
- Allowing the authority to provide nutritional services including healthy meals for families who may not have access to meals during the interrupted period of social distancing.

North Carolina is also seeking waiver authority on behalf of our hospital providers for the following:

- 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 can accept them without sharing the data requested by the regulators;
- Medicare Conditions of Participation (CoPs).
    - Physical Environment. 42 C.F.R. §482.41; A-0700 et seq;
        - 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.
        - Permit basic evaluation, specimen collection, and treatment to occur in patient vehicles, assuming patient safety and comfort. As many facilities are standing up drive through specimen collection sites, we'd like to request that basic evaluation and treatment be allowed in patient vehicles in order to prevent potential spread of the virus to the facility.
    - Patient Rights. 42 C.F.R. §482.13. Waive enforcement of patient rights related to personal privacy, confidentiality (see HIPAA request above), orders for seclusion, and patient visitation rights.
    - 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 personal protective equipment.
    - 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.
    - 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.
    - Medical Staff. 42 C.F.R. §482.22(a); A-0341 Permit physicians whose privileges will expire and new physicians to practice before full medical staff/governing body review and approval, provided that such review and approval would be secured at the next practical opportunity. This will keep clinicians on the front line and allow hospitals and health systems to prioritize patient care needs during the emergency.
    - Medical Records Timing**.** 42 C.F.R. §482.24; A-0469 Medical records can be fully completed later than 30 days following discharge but must be completed no later than 60 days following the termination of the emergency period. This flexibility will allow clinicians to focus on the care needs at hand and complete full documentation later.
- 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.

- Telehealth. 42 C.F.R. §410.78(b).
    - 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.
    - Eliminate the requirement that in order to bill for a telehealth service a provider or a provider in their practice or in the health system must have furnished a service to that individual within the previous three years so that telehealth codes can be billed even for first-time patients.
- 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.
- Delivery of Services in Alternate Clinic Locations. to bill for their Prospective Payment System (PPS) rate, or other permissible. Waiver/flexibility to allow Federally Qualified Health Centers (FQHC),Rural Health Clinics (RHC) and IHS/Tribal providers 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.
- Flexibility for Teaching Hospitals**.** Allow flexibility in how the teaching physician is present with the patient and resident including real time-audio video or access through a window.
- Flexibility in Patient Self Determination Act Requirements. 42 CFR 489.102
- Timely Filing Requirements for Billing. 42 U.S.C. 1396a(a)(54), and 42 U.S.C.
- 1395cc(a)(1)(57), (w), 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.
- Flexibility in Equipment Requirements. Waiver of certain equipment requirements in CMS Hospital Equipment Maintenance Requirements guidance issued in December 20, 2013 in order to maintain the health and safety of the hospitals' patients and providers.
- Flexibility for Concurrent Respiratory Therapy. Allow providers to access Medicare reimbursement for concurrent respiratory therapy (i.e., when a respiratory professional treats more than one patient at a time) in order to manage large volumes of patients requiring treatment.