

March 20, 2020

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

Subject: Request for waivers under Section 1135 of the Social Security Act

Dear Ms. Glaze,

The state of Oregon, by and through the Oregon Health Authority (OHA), respectfully requests that the Centers for Medicare and Medicaid Services (CMS) approves blanket waivers of certain federal healthcare laws and requirements necessary to adequately and efficiently address the public health emergency related to the COVID-19 pandemic. The requests made by OHA will allow the state the flexibility required to assure access to and provision of necessary services and supports to individuals affected by this pandemic. Oregon requests temporary modifications and waivers to certain Medicare, Medicaid, CHIP, and HIPAA requirements including but not limited to requests that apply to Medicaid services administered through the OHA and Oregon's operating agency, the Department of Human Services.

On January 31, 2020, the Secretary of the Department of Health and Human Services (HHS) declared a nationwide public health emergency related to the COVID-19 pandemic. On March 8, 2020, Oregon Governor Kate Brown declared a state of emergency to boost the staffing and equipment capacity to respond to the pandemic. On March 13, 2020, President Trump declared a national emergency under the Stafford Act which afforded states the ability to seek flexibilities under Section 1135 of the Social Security Act. The attached documents constitute Oregon's request for blanket waivers and flexibilities, including but not limited to the blanket waivers already approved by President Trump on March 13, 2020. To the extent CMS believes that anything in this request cannot be approved under Section 1135, but can be approved under Section 1115 of the Social Security Act, Oregon requests that its request also be treated as an application for an emergency Section 1115 demonstration.

The flexibilities and blanket waivers requested by Oregon include but are not limited to, presumptive Medicaid eligibility, eligibility determinations and redeterminations, Medicaid fair hearings, condition of participation, provider enrollments, HIPAA requirements, service authorizations and utilizations controls, telehealth/telemedicine, temporary facilities, and sanctions and penalties and will allow Oregon to nimbly respond to the ever-changing demands of the COVID-19 pandemic. Assuring the health and welfare of Oregonians is of the highest priority and of utmost importance in the best of times and certainly right now.

OHA appreciates the CMS' guidance, collaboration and flexibilities, but most especially during this unprecedented pandemic. We anxiously await CMS' response to this request for blanket waivers and flexibility and look forward to working with you to meet the ongoing needs of Oregonians. If you have any questions or would like further information, please do not hesitate to contact me, lori.a.coyner@state.or.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Coyner". The signature is fluid and cursive, with a large initial "L" and "C".

Lori Coyner, MA
Medicaid Director

cc: Seema Verma, Administrator, CMS
Calder Lynch, Director of Medicaid and CHIP Services, CMS
Patrick Allen, Director, Oregon Health Authority
Tina Edlund, Health Care Policy Adviser, Office of the Governor

Oregon 1135 Disaster Relief Waiver COVID-19 Pandemic

The President's declaration of a national emergency related to COVID-19 and the Secretary's public health emergency together give the Secretary authority pursuant to Section 1135 of the Social Security Act to temporarily modify or waive certain Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), and Health Insurance Portability and Accountability Act ("HIPAA") requirements in the declared national emergency or disaster ("1135 Waiver").

Oregon requests temporary modifications and waivers to certain Medicare, Medicaid, CHIP, and HIPAA requirements, as set forth below. It is Oregon's understanding that the national blanket waivers authorized by Centers for Medicare and Medicaid Services ("CMS") on March 13, 2020 and the subsequent telehealth waiver are in effect and available now, without notification to CMS or request to CMS. To the extent notification or request is required, Oregon hereby requests it.

Oregon requests a Medicaid and CHIP blanket waiver for flexibilities related to areas of section 1135 of the Social Security Act to adequately and efficiently address the public health emergency related to the COVID-19 pandemic. This waiver request is in addition to the blanket waivers authorized by Centers for Medicare and Medicaid Services (CMS), March 13, 2020.

One purpose of this 1135 waiver is to give Oregon Medicaid and CHIP the maximum flexibility to make necessary changes as circumstances related to this emergency dictate without the need to submit proposed changes to CMS for approval. This flexibility ensures continued access to needed services and the ability to maintain an adequate pool of providers while enabling providers to furnish needed items and services in good faith during times of disaster and be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Utilization of these flexibilities by Oregon's hospitals is detailed in Attachment 2.

To the extent CMS believes that any of its requests for flexibility cannot be approved under Section 1135 but can be approved under Section 1115 of the Social Security Act, Oregon requests that this waiver application also be treated as an application for an emergency Section 1115 demonstration.

All requirements of Oregon's Medicaid and CHIP program expressed in law, regulation and policy statement, not expressly waived in this list or other approved waivers, shall apply.

Alternative Care Sites.

- (1)** In addition to the existing blanket waivers, we request CMS authorize institutional providers (e.g. hospitals), as well as federal qualified health centers and rural health

centers, to set up alternative care sites, outside licensed and traditional space, to provide for both COVID-19 screening, but also to isolate or seclude any populations necessary to prevent the spread of the virus. This would include tents, parking lots, use of routine care units for special care patients (and vice versa), such as allowing use of routine units for ED, CCU, ICU, and NICU. This would also include transfer of acute care patients with less acuity to alternative settings not limited to distinct part units, such as freestanding inpatient and psychiatric hospitals, or from an IPPS hospital to a CAH to free up space in facilities that can accommodate the most acute patients. Hospitals and other providers need relief not just from conditions of participation under Medicare and Medicaid, but also clear guidance around how these alternative locations can be billed as if they were a traditional location. This will also require relief from Medicare's provider-based rule (42 C.F.R. § 413.65), or other payment requirements specific to CAHs, IRFs, and special care units (e.g., if the patient meets urgent/emergent criteria those codes may be billed outside a special unit). Unlike in prior national emergency situations, there will also be situations where the patient moved from one facility to another should be billable by the recipient facility and not the transferring facility, yet the current blanket waivers speak to billing by an IPPS hospital for acute care patients placed in its own distinct part units, whereas it would be operationally impossible for an IPPS hospital to bill for an acute care patients transferred to a freestanding IRF or CAH.

- a. Waiver of certain conditions of participation and certification requirements for opening an alternative care site if the state determines there is a need to quickly stand up a temporary COVID-19 facility.
- b. Physical Environment. – Alternative care site buildings/space can be certified for use, provided sufficient safety and comfort is provided for residents and staff – allows state to open a temporary COVID-19 alternative care site to assist COVID-19 positive residents to receive care and services during treatment for the 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.

I. Provider Network

1135(b)(1)(A) conditions of participation or other certification requirements for an individual health care provider or types of providers (including but not limited to hospitals, SNF, IRF, HHA, Hospice, ASC)

- a) Waive provider screening requirements to enroll new Medicaid/CHIP or Medicare providers provisionally and temporarily, including but not limited to:
 - i. Temporarily waive payment of application fee to temporarily enroll a provider.
 - ii. Temporarily waive criminal background checks associated to temporarily enroll a provider.
 - iii. Temporarily waive site visits to temporarily enroll a provider.
 - iv. Streamline provider enrollment requirements when enrolling providers.
 - v. Temporarily cease revalidation of providers who are located in-state or otherwise directly impacted by the emergency.
 - vi. Temporary authority to rely upon screening that is performed by other State Medicaid/CHIP Agencies and/or Medicare.
- b) Allow physicians whose privileges will expire and new physicians to practice before full medical staff/governing body review and approval.
 - i. Suspend review and approval for the duration of the pandemic.
- c) Allow physicians such as pathologists to make patient diagnoses from to decrease the risk of COVID19 infection for them and for patients.

1135(b)(1)(B) program participation and similar requirements for an individual health care provider or types of providers (including but not limited to hospitals, SNF, IRF, HHA, Hospice, ASC)

- a) Temporarily suspend pending enforcement or termination action or denial of payment sanction to a specific provider.
- b) Temporarily allow non-emergency ambulance suppliers.
- c) Temporarily allow facilities not certified to participate in Medicaid/CHIP to provide services to Medicaid/CHIP enrollees and receive payment.
- d) Allow facilities to provide services and receive payments for services in alternative settings when a provider's facility is not available, including but not limited to:
 - i. Allow a non-operational hospital or other sites used by a hospital to provide services, e.g. hotels, community centers, etc., to receive payment for services provided by outpatient and supplemental service settings on the hospital license (clinics, hospice and home health providers, ambulatory surgery, etc.). These shall include make-shift locations for clinical and mandatory and voluntary quarantine sites awaiting test results.
- e) The state and/or providers create a new isolation and quarantine system to provide safe places for people who cannot quarantine at home.
- f) The state and/or providers create emergency congregate assessment center/recovery facilities to slow the spread.
- g) Waive requirement that hospitals are required to provide information about policies to patients "upon admission." This would not apply to the requirement hospitals inquire about the presence of an advance directive.
- h) 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.

- i) 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.
- j) Allow medical records to be fully completed later than 30 days following discharge.
- k) Permit treatment to occur in patient vehicles, assuming patient safety and comfort. In the event facilities stand up drive through specimen collection sites, Oregon requests basic evaluation and treatment be allowed in patient vehicles in order to prevent potential spread of the virus to the facility.
- l) Process certified bed increases for hospitals (on or off-campus) and nursing homes, per the request from the facility.
- m) Allow flexibilities for Skilled Nursing Facilities and Critical Access Hospital for bed limits or admission criteria; Waive staffing ratio requirements to allow care of patients during staff shortages
- n) Allow hospitals to discharge patients who no longer need acute care based solely upon which post-acute providers that can accept them without submitting information to regulators that might otherwise be required.

II. Service Authorizations and Utilization control

1135(b)(1)(c) pre-approval requirements

- a) Temporarily suspend all prior authorization requirements.
 - i. Suspension of Level I and Level II PASRR screening activities for up to 30 days such that everyone entering a Nursing Facility is treated as an “exempted hospital discharge”.
- b) Require FFS providers to extend prior authorizations through the termination of the emergency.
- c) Waive limitations on who can prescribe certain covered OHP benefits
- d) Waive 42 C.F.R. § 484.55(a) to allow home health agencies to perform certifications, initial assessments and determine patients’ homebound status remotely or by record review.

1135(b)(2) Requirements that physicians and other health care professionals be licensed in the State in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area.

- a) Delay any annual recertification and training requirements for physicians for the duration of the public health emergency.
- b) Broaden ability of physician extenders, including but not limited to nurse practitioners and physician assistants, to bill at 85% of the Medicaid physician fee schedule without direct oversight by physician.
- c) Create provisions allowing for additional flexibilities to allow for the utilization of physician extenders in place of Medical Directors and attending physicians, and via telehealth options.

1135(b)(3) Waive actions under section 1867 (relating to examination and treatment for emergency medical conditions and women in labor) for-

- a) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;
- b) the direction or relocation of an individual to receive medical screening in an alternative location—
 - (i) pursuant to an appropriate State emergency preparedness plan; or (ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State.

1135(b)(4) Sanctions under sections 1877(g) (relating to limitations on physician referral).

Waive sanctions under section 1877(g) of the Social Security Act (relating to limitations on physician referral). Allows 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.

This should also reach the provision of free services, space, or other supports to physicians that are experiencing financial difficulties due the Administration's recent direct that health care providers discontinue providing any non-essential, elective care, and the overall negative impact that the pandemic is having on the U.S. economy. Encourage the OIG to expand its position on waiving cost-sharing beyond just telehealth services.

1135(b)(5) Deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived:

- a) Adjust performance deadlines and timetables for required activities.
- b) Temporarily suspend 2-week aide supervision requirement by a registered nurse for home health agencies.
- c) Waive the requirements for ambulatory surgery centers in 42 CFR § 416.2 regarding the purpose of admission and the duration of stay so that patients can be admitted for stays expected to exceed 24 hours that do not involve surgery.
- d) Timely Filing Requirements for Billing. Temporarily waive timely filing requirements in 42 CFR 424.44 to allow providers getting correct coding and other structural pieces built into their systems and even payer ability to adjudicate.

1135(b)(6) Limitations on payments under section 1851(i) for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan. This would allow plans to claim more for health care items and services outside of the Medicare limitations.

1135(b)(7) Sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note)

- a) Waive:
 - (A) section 164.510 of title 45 Code of Federal Regulations relating to
 - (i) requirements to obtain a patient's agreement to speak with family members or friends; And
 - (ii) the requirement to honor a request to opt out of the facility directory
 - (B) section 164.520 of such title, relating to the requirement to distribute a notice; or
 - (C) section 164.522 of such title, relating to—

- (i) the patient's right to request privacy restrictions; and
 - (ii) the patient's right to request confidential communications.
- b) Waive 42 C.F.R. §482.13 regarding enforcement of patient rights related to personal privacy, confidentiality (see HIPAA request above), orders for seclusion, and patient visitation rights.

III. Other Medicaid/CHIP Waivers and temporary flexibilities requested

- a) Request a blanket waiver be issued to temporarily delay aspects of the Medicaid/CHIP Fair Hearing process including, but not limited to, allowing members to have more than 120 days (in the case of a managed care appeal) or 90 days (in the case of an eligibility or fee-for-service appeal) to request a fair hearing.
- e) COVID-19 Lab Codes: Pay U0001 and U0002 at 100% Medicare; with no AB 97 reduction.
- f) Deem testing for COVID-19 as an emergency service and upon positive test all treatment services as an emergency service.
- g) Expand Hospital Presumptive Eligibility to include the aged, blind and disabled populations.
- h) Allow the State to designate certified community partner organizations as qualified entities and allow them to make presumptive determinations for MAGI medical programs.
- i) 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 in a timely manner.
- j) 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.
- k) 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.
- l) Delay annual eligibility re-determinations for the duration of the public health emergency.
- m) Suspend terminations of Medicaid/CHIP eligibility due to an enrollee’s failure to respond to eligibility redetermination requests during the public health emergency.
- n) Allow Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers to bill for their contracted Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings, such as a mobile clinic or temporary location.

- o) To the extent that the 1135 waiver or other regulations require use of HIPAA and 42 CFR part 2 compliant communications tools for telehealth:
 - i. HHS/OHA will not conduct audits to ensure that platforms are compliant;
 - ii. For billing codes (i.e. telephonic and online portal) which require an established patient relationship or patient-initiated services, OHA will not conduct audits to ensure the patient was an existing patient or that the patient initiated the service;
 - iii. OHA will not conduct audits to ensure there is signed consent to provide telehealth, online or telephone services.
- p) Remove limitations on telephonic and virtual communication for clinicians, FQHCs, RHCs, IHS-MOA 638 clinics, BH providers, and home health.
- q) To the extent that the 1135 waiver or other regulations require the use of synchronous audio/video for telehealth services, allow telephone services to be used in lieu of synchronous audio and video when synchronous audio and video are not available or practical for providers or patients.
- r) Allow for reimbursement for telephone visits at the same rate as telehealth video visits, and clearly allow hospitals (and other institutional providers) to bill all these codes, including HCPCS G2012 and G0071, which do not currently appear eligible for OPSS payment. 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.
- s) Create codes recognizing costs incurred by institutional providers, related to staff and equipment, for multi-day remote monitoring of patients in homes and alternative care settings.
- t) During this pandemic, OHA will ask providers to use modifiers to identify services provided by telephone under these circumstances and provide pay parity with in-person services, and modifiers to identify services provided by synchronous audio and video.
- u) Medicaid requests the same waivers for Medicare services as applicable generally and specifically for the telehealth provisions requested above.
- v) Temporary housing for homeless related to COVID-19.
- w) Flexibility on upcoming CMS compliance filings.
- x) Waive physician order requirements for care management or broader permissions to conduct care management via telehealth.
- y) Allow state to draw federal financing match for payments, such as hardship, incentive, hazard, or supplemental payments to incentivize, stabilize and retain providers who suffer extreme disruptions to their standard business model and/or revenue streams or risk to their own personal health and safety as a result of the public health emergency.
- z) Home Health providers and other provider types may need enhanced payment.
- aa) Opening a COVID-19 Skilled Nursing Facility/Nursing Facility:

- i. 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.
 - ii. Expedite certification process and expedite approval process from the Medicare Administrative Contractor (MAC)
 - iii. Expedite Life Safety Code Process
 - iv. 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.
 - v. Resident Groups - 42 CFR 483.10(f)(5) Residents have the right to organize and participate in resident groups – given social distancing guidelines and requests that facilities limit group activities within the resident population, Oregon SNF/NFs will not be able to meet the Resident Council requirements during this crisis.
 - vi. 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. Oregon requests an exemption to the 4-month rule and to the full training requirements. Due to an already existing workforce shortage and potential 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, facilities are unable to fill critical Nurse Aid positions with staff who have completed training and testing.
- bb) 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.
 - cc) 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.
 - dd) 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.
 - ee) 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.

- ff) Freedom of Choice - Section 1902(a)(23)(A). To enable the State to restrict freedom of choice of provider.
- gg) 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.
- hh) Amount, Duration, and Scope – Section 1902(a)(10)(B). To the extent necessary to enable the state to offer different benefits to affected beneficiaries.
- ii) 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.
- jj) 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)].
- kk) 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 operating in Oregon.
- ll) Requirements related to home and community-based settings in order to ensure the health, safety and welfare of affected beneficiaries [441.301(c)(4)].
- mm) 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.
 - i. Medicaid Administrative Claiming program: request authority to expand the match to other public health services not currently covered.
- nn) Waive signature requirements on level of care assessments, plans of care and other required supporting documentation.
- oo) 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.
- pp) Broadly waive any other face-to-face requirement.
- qq) 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, for clarity, the state requests a blanket waiver authority for the following:
 - i. Adjusting performance deadlines and timetables for required reporting and oversight activities;
 - ii. Modifying deadlines for CMS Outcome and Assessment Information Set (OASIS) and Minimum Data Set (MDS) assessments and transmission;
 - iii. Allow Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies;

- iv. 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;
- rr) Waive 42 CFR 170(4) requirements for Non-Emergency Medical Transportation (NEMT), which currently prohibits contracted transportation brokers from directly providing trips for Medicaid clients.
- ss) 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.
- tt) Temporarily expand eligibility to in-home services for an individual who does not meet functional eligibility, when a congregate site such as adult day center closures.
- uu) Waive of the face-to-face requirement for conducting reassessments and instead provide the option to conduct reassessments via telephone or other remote option for the following: Personal Care Services (42 CFR 440.167), Community-First Choice Option under 1915(k), Self-directed services under 1915(j), and Home and Community-Based Services under 1915(i).
- vv) Waive annual reassessment requirements under 1915(i), 1915(j), and 1915(k) authorities when remote options are not available or feasible. Extend current service plans up to 60 days after the end of the declaration of health care emergency when remote options for reassessment are not available or feasible.
- ww) Waive annual institutional level of care reassessment requirements under 1915(j) and 1915(k). Extend level of care determinations for up to 60 days after the end of the declaration of health emergency when remote options for reassessment are not available or feasible.
- xx) Request exemption to staff training and orientation requirements, **Orientation of staff §482.13(f)(4)**
- yy) Permit the use of personal protective equipment outside of and beyond the specific manufacturer's instructions for use. This is including but not limited to surgical masks, N95 masks, face shields and gowns. **Infection control Use of PPE §482.42(a)(2)-(3)**
- zz) The hospital must ensure that the nursing staff develops and keeps current a nursing care plan for each patient *that reflects the patient's goals and the nursing care to be provided to meet the patient's needs.* **Staffing and delivery of care §482.23(b)(4) -**
- aaa) Permit face masks can be removed and retained in the compounding area to be re-donned and reused by the staff member for same day only. **Sterile Compounding. §482.25(b)(1) and USP 797**
- bbb) Allow verbal orders may be used more than 'infrequently' (read-back verification is done) and authentication may occur later than 48 hours. **Verbal Orders §482.24, A-0407, A-0454, A-0457**

- ccc) The State of Oregon requests a waiver of public notice and Tribal consultation. Public notice for state plan amendments (SPAs) are required under 42 C.F.R 447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. 447.57 for changes to premiums and cost sharing and 42 C.F.R. 440.386 for changes to Alternative Benefit Plans (ABPs). This is to ensure that the impacted public has reasonable opportunity to comment on such SPAs. Tribal consultation is required for SPAs under Section 5006(e) of American Recovery and Reinvestment Act (ARRA) in 2009. OHA will make all relevant information available to the public and Tribal entities so they are aware of the changes.
- ddd) Waive 42 C.F.R. § 482.22 and any other requirements applicable to this waiver to allow hospitals to recognize, without further action, the full range of credentials and privileges of medical staff members and allied health professionals granted by any other hospital within the hospital's integrated delivery system. Allow hospitals to recognize, without further action, the full range of credentials and privileges of medical staff members and allied health professionals granted by any other hospital. Allow physicians whose privileges will expire during the emergency period to provide services before full medical staff/governing body review and approval. Allow physicians to practice before full medical staff/governing body review and approval.
- eee) Waive requirements to allow freestanding IRFs, psychiatric hospitals, and rehabilitation facilities to bill for acute care so long as that is the level of care, provided the patient's medical record indicates the patient is an acute care inpatient being housed because of capacity issues related to the emergency.
- fff) Waive 42 C.F.R. § 482.24 and any other requirements applicable to this waiver to allow verbal orders for medical and/or behavioral health to be used more than infrequently. Allow authentication to occur later than 48 hours.
- ggg) Waive 42 C.F.R. § 482.25(b)(1) and USP 797 and any other requirements applicable to this waiver to permit face masks to be removed and retained in the compounding area and permit them to be re-donned and reused during the same work shift.
- hhh) Waive 42 C.F.R. § 482.13(g)(1)(i)-(ii) and any other requirements applicable to this waiver to allow the reporting of patients whose death is caused by their disease process and who required soft wrist restraints to prevent pulling tubes/lvs to be reported later than close of business next business day, provided any death where restraint may have contributed must be reported within standard time limits.

To the extent CMS believes that any of these requests cannot be approved under Section 1135 but can be approved under Section 1115 of the Social Security Act, Oregon requests that the request also be treated as an application for an emergency Section 1115 demonstration.

Effective Date and Duration of Waiver

Oregon requests an effective date of March 1, 2020 with waiver approval until the termination of the March 1, 2020 declaration of public health emergency, with the potential for request for a 60-day extension as allowable in Section 1135(e)(2).

Utilization/Justification of Flexibilities for Oregon Hospitals

Source Document	What is waivable	Justification for Waiver	Oregon Hospitals Requests
<p>CMS Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With a §1135 Waiver Question 1135B-2</p>	<p>1. a. conditions of participation or other certification requirements for an individual health care provider or types of providers; b. program participation and similar requirements for an individual health care provider or types of providers; and c. pre-approval requirements.</p>	<p>Justifications for these requests would likely be facility-specific, therefore we are unlikely to request a blanket waiver EXCEPT we could ask for a waiver for hospitals of the 42 CFR 482.22 Condition of Participation: Medical Staff</p>	<p>The blanket waiver request would waive requirements of Condition of Participation: Medical Staff to allow all hospitals to use an abbreviated process to privilege and credential additional staff including out-of-state practitioners who are permitted by Oregon professional licensing agencies to practice in Oregon in the current emergency.</p>