



March 19, 2020

ROPHIDSC@cms.hhs.gov  
Centers for Medicare & Medicaid Services  
Northeast Consortium  
JFK Federal Building  
Boston, Massachusetts 02203-0003

RE: New Hampshire Section 1135 Waiver Request

Provider Name/Type - All New Hampshire Hospitals

Dear Sir/Madam:

The State of New Hampshire has confirmed the presence of COVID-19, with several positive or presumptively positive cases and numerous Persons Under Investigation (PUIs). Based on the experience of other states, we anticipate the number of cases to steadily increase with the potential to overwhelm the health care system, especially hospitals. The New Hampshire Hospital Association appreciates the leadership of the Centers for Medicare & Medicaid Services in providing a number of blanket waivers to the Medicare Conditions of Participation (CoP), among other federal requirements. Waiving the 25-bed limit and the 96-hour length-of-stay requirement for critical access hospitals is key for our members and will ensure necessary care is delivered in rural areas of the state. Thank you for confirming the CMS blanket waivers under Section 1135 dated March 13, 2020, apply automatically to all hospitals.

To ensure that New Hampshire is poised to rapidly and adequately respond to any surge of COVID-19 cases in the state, and to avoid inundating CMS with individual waiver requests, we request CMS grant the following additional blanket waivers to the state. These requests, based on communication with New Hampshire hospitals, are targeted to meeting the most critical of our members' needs.

**1. Suspend the EMTALA requirements for a medical screening examination** (42 U.S.C. § 1395dd(a) and accompanying regulations). Due to capacity issues, New Hampshire hospitals request the ability to triage individuals who come to the emergency department and divert individuals without an obvious emergency medical condition to alternative COVID-19 screening sites. **We also request CMS expand the definition of appropriate transfer** (42 U.S.C. § 1395dd(c)(2)) to allow for the transfer of patients to a facility offering a lower level of care, so long as the accepting facility has the capacity and capability to treat the patient. Similarly, we request hospitals be allowed to deny transfers unless the accepting facility offers a level of care needed by the patient that cannot be provided by the transferring hospital. **Additionally, waive the requirement to obtain special designation for Qualified Medical Professions (QMPs) to ensure hospitals can expand the number of available personnel to conduct medical screening examinations (MSE).**

This will permit the medical screening examination to be conducted by other qualified staff authorized by the hospital and acting within their state scope of practice and licensure, who are not formally designated to perform medical screening examinations in the hospital by-laws or in the rules and regulations.

**2. Suspend the CoP Physical Environment requirements for alternate screening or patient care sites** (42 C.F.R. § 482.41). New Hampshire hospitals are in the process of standing up on- and off-campus COVID-19 screening and testing sites. Due to the temporary nature of these facilities, it will be unfeasible to meet the exacting standards for physical environment found in the CoPs.

Additionally, if and when hospitals experience patient surge beyond their licensed capacity, they may need to convert areas not currently used for patient care to treatment areas. Authorizing alternate, but safe care areas for less acute patients will ensure adequate acute and intensive care beds for those in need of higher levels of care. Encompassed within this request is the ability for hospitals to provide care to patients in their vehicles at drive-through testing sites and non-PPS hospitals to treat medical/surgical patients.

**3. Waive the requirement to submit a form 855A to the MAC if an alternate/ new screening or patient care site is set up which is remote from the hospital's campus.** This will streamline the hospital's ability to designate a new authorized outpatient location from which charges for testing to Medicare / Medicaid and other insurers can be generated.

**4. Waive the requirement under the Conditions of Participation (CoP) 685.642(a)(8) that discharge planners must assist patients in selecting a post-acute provider by using and sharing data that includes data on quality measures and resource use measures.** Gathering of this data is time intensive and options for subacute transfers are expected to be limited.

**5. Waive the CAH 96-hour condition of payment in addition to the 96-hour average length of stay.** Waiving the requirement that a physician certify a patient can reasonably be expected to be discharged within 96 hours would provide critical flexibility for care in rural areas that may not have other options for inpatient care.

**6. Allow hospitals to disregard provisions in their medical staff bylaws relating to expiration of and granting of privileges** (42 C.F.R. § 482.22). Granting hospitals flexibility to grant extensions to existing privileges and/or granting new privileges to new physicians absent full review and approval of the medical staff or governing body will ensure consistent staffing levels throughout the duration of this emergency.

**7. Waive Prior Authorization for Post-acute Care (PAC).**

Requiring that plans waive prior authorization requirements for PAC placement would enable hospitals to free up inpatient bed capacity.

**8. Relax documentation requirements for transfers to post-acute care** (42 C.F.R. § 482.43). Hospitals will need to efficiently discharge patients to post-acute care to free up needed bed space for incoming patients. The CoP includes numerous data sharing requirements that impede the ability to move patients into the next care setting. Allowing expeditious patient transfers for the duration of the emergency will ensure patients who need acute care have access.

**9. Medicare Outpatient Observation Notice (MOON).**

In addition to the Centers for Medicare & Medicaid Services' (CMS) waiver of the skilled nursing facility (SNF) 3-day rule, waiving the MOON written and oral notification requirements is appropriate since undergoing observation care will have no implications for SNF eligibility.

**10. Waive certain HIPAA privacy and security requirements to better facilitate care (45 C.F.R. Part 164).**

The HIPAA security rule requires that all electronic transmissions of protected health information be encrypted. The Department of Health and Human Services, through both CMS and the Office for Civil Rights, have issued advisories against transmitting PHI via text or unencrypted email channels. However, those tools serve as valuable means of rapid communication between providers, and between health care workers and patients. Additionally, hospital staff may need to communicate with a patient's family, friends or other contacts to satisfy urgent public health epidemiological needs absent clear approval of the patient. Finally, due to anticipated patient surge situations, we request the requirement to provide each patient a Notice of Privacy Practices on the date of first service delivery or as soon as practicable thereafter, as many patients may be rapidly discharged to other care settings.

**11. Relax certain standards relating to protective equipment during sterile compounding (42 C.F.R. § 482.25).**

To conserve face masks, which likely are to be in short supply, we request that personnel engaged in sterile compounding be allowed to remove and retain face masks in the compounding area to be re-donned and used throughout a single work shift.

**12. Allow regular use of verbal orders (42 C.F.R. § 482.24).** Allowing the use of verbal orders during a surge will allow facilities to triage, screen, stabilize and treat patients more efficiently and effectively. We request that verbal orders be permitted with read-back verification and with authentication to follow within a reasonable time. Similarly, **allowing hospitals to complete medical records outside the 30-day requirement** will allow health care providers to focus on immediate care needs as opposed to paperwork.

**13. Suspend certain requirements relating to patient rights (42 C.F.R. § 482.13).** In emergency situations, especially those involving patient surge, it is impractical to require hospitals to provide each patient an individual notice of rights. Hospitals also must be allowed to temporarily suspend their grievance process to focus on urgent care needs and patient safety. Additionally, the need to care for patients outside typical care settings may infringe on personal privacy rights. Finally, the nature of the COVID-19 virus may require visitor limitations and seclusion against a patient's express desires.

**14. Suspend requirements for face-to-face consultation by physicians prior to discharge to home health agencies (42 C.F.R. 484.55).** Expediting discharge to home health agencies can relieve stress on inpatient settings and long-term care. Home health agency staff may perform the necessary certifications and initial assessments remotely or by record review, allowing physicians and advanced practice clinicians to focus on patients who require acute care.

**15. Flexibility for Teaching Hospitals.**

Medicare generally requires that a teaching physician be physically present in the room/area with the patient and medical resident in order to bill as the teaching physician. Because hospitals are running low on PPE and also want to limit exposure of both patients and staff to other people as much as possible, we request flexibility in this requirement. Flexible approaches might include real-time

audio/video or supervision through a window for the teaching physician. These flexible approaches should be covered and reimbursed.

**16. Allow for Critical Access Hospitals (CAH) to receive relief from meeting scheduled payments associated with cost report settlements from prior fiscal years. Also allow for flexibility for requests for payments ahead of final settlements to alleviate cash flow concerns of CAHs.**

**17. Ensure coverage and payment of costs associated with hospitalization of patients with presenting symptoms that may or may not ultimately result in a positive COVID-19 diagnosis.** Generally, insurers make coverage decisions in part by assessing whether care was medically necessary, and many insurers adjudicate medical necessity using information that becomes available during the course of treatment or testing. This approach could result in many coverage denials for individuals who were originally suspected to have coronavirus but who ultimately are found to have the flu. The government should clarify that coverage decisions must be made on the presenting symptoms, not the final diagnosis.

**18. Suspend all CMS surveys except those of the highest priority listed in QSO Letter 20-12 targeting real potential Immediate Jeopardy concerns for patient health and safety.** This will allow hospitals to continue to serve their communities and prepare for the surge of patients with COVID-19 diagnosis while continuing to care for others with urgent medical needs.

**19. Waive the several requirements within the Conditions of Participation at (482.24(c1 &2), 482.51(b)(2), 482.24(c)(4)(v) and 482.13(b)(3) as well as equivalent standards at part 485, that require the physical signature of the patient or the patient's representative.** We ask for this relief in the interest of reducing patient anxiety over sharing pens at the emergency department registration desk or even at the bedside. Instead we request the option to allow our hospital staff to attest to the patient's agreement and acceptance of the content of the consent or the IMM, or other clinical documentation as the case may be.

The contact person for this waiver request is:

Steve Ahnen, President  
New Hampshire Hospital Association  
125 Airport Road  
Concord, NH 03301  
[sahren@nhha.org](mailto:sahren@nhha.org)  
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Email to CMS Regional Office: [ROPHIDSC@cms.hhs.gov](mailto:ROPHIDSC@cms.hhs.gov)

The expected duration of the waiver is March 1, 2020 (the effective date of the President's declaration under the National Emergencies Act) until the COVID-19 national public health emergency terminates.

Thank you for considering these requests so that New Hampshire hospitals can manage and mitigate the potentially devastating effects of the COVID-19 outbreak. Our members already are facing overburdened emergency departments, staffing shortages, supply chain pressures and significant

uncertainties and unknowns for the duration of this public health emergency. Blanket waivers of the foregoing requirements will help the health care delivery system meet the needs of the state's citizens and help flatten the curve of the pandemic.

Sincerely,

A handwritten signature in cursive script that reads "Steve Ahnen". The signature is written in dark ink and is positioned above the printed name and title.

Steve Ahnen  
President