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Department of Health Services

DIVISION OF MEDICAID SERVICES

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March 24, 2020

Jackie Glaze
CMS Acting Director,
Medicaid and CHIP Operations Group Center for Medicaid and CHIP Services
61 Forsythe St SW Suite 4T20
Atlanta, GA 30303-8909

Via email transmittal to Jackie.Glaze@cms.hhs.gov

Dear Ms. Glaze,

On January 31, 2020, in anticipation of the effects of Novel Coronavirus Disease (COVID-19), Secretary of Health and Human Services Alex Azar declared a public health emergency pursuant to Section 319 of the Public Health Services Act. Secretary Azar's declarations were retroactively effective to January 27, 2020. 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. On March 13, 2020, Secretary Azar issued his formal waiver approval authority under Section 1135.

The Wisconsin Department of Health Services (DHS) writes to request approval for the detailed flexibilities listed below under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the COVID-19 Disease. The list represents Wisconsin's initial requested flexibilities under the Section 1135 authority in connection to the COVID-19 outbreak and emergency. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHS may subsequently request approval for additional flexibilities. DHS remains committed to submitting any additional request promptly as the Department identifies flexibilities needed to meet the COVID-19 emergency in Wisconsin.

Please note that Wisconsin is implementing all of the blanket waivers issued by CMS on March 13, 2020 in Medicaid and CHIP, to the extent applicable. In addition, Wisconsin expects its licensed providers will operate under all CMS blanket waivers announced by CMS on March 13, 2020. The purpose of this letter is to seek additional waivers as authorized by Section 1135 for CMS approval. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHS requests a retroactive effective date of March 1, 2020.

1. **Provider Participation, Billing Requirements and Conditions for Payment.**
Wisconsin DHS is requesting that DHHS grant temporary authority to:

1.1 Allow providers to receive payments for services provided to affected beneficiaries in alternative physical settings, such as mobile testing sites, temporary shelters or other non-traditional or alternative care facilities.

1.2 Waive Pre-Admission Screening and Annual Resident Review (PASSR Level I and Level II Assessment) when members are transferred. 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.

1.3 Waive the requirement for actuarially sound Medicaid managed care rates, under 42 C.F.R. Part 438, for calendar year 2020.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 a Section 1115 waiver, in which in light of the emergency, the state requests that it would not have to meet transparency requirements.

1.4 Allow flexibility with regard to managed care directed payments, to ensure that payments can be made to meet critical needs in the context of COVID-19 that may not entirely conform with current CMS requirements relating to ensuring payments have a basis in utilization and relate to quality initiatives. Wisconsin seeks flexibility in gaining approvals for payments made under 42 C.F.R. § 438.6(c) in a more expedited fashion than offered under the current preprint approval process, and immediate authority to make payments as authorized by the legislature or as needed under the current emergency declaration.

1.5 Allow hospitals who have obtained state licensure but not yet received accreditation from The Joint Commission to bill Medicaid for the duration of the public health emergency.

1.6 Allow the state to draw federal financing match for payments, such as hardship or supplemental payments, to stabilize and retain providers who suffer extreme disruptions to their standard business model and/or revenue streams as a result of the public health emergency.

1.7 Allow the state to establish drug reimbursement rates and pharmacy reimbursement outside of the reimbursement methodology requirements defined in 42 C.F.R. §§ 447.500-447.522.

2. Provider Screening and Enrollment Requirements. Wisconsin DHS is requesting that DHHS grant temporary authority to:

2.1 Waive payment of application fee to temporarily enroll a provider for ninety (90) days or until the termination of the novel COVID-19 declaration of emergency, whichever is longer. (42 C.F.R. § 455.460).

2.2 Waive pre-enrollment criminal background checks for Medicare-enrolled providers to temporarily enroll a provider for ninety (90) days or until the termination of the novel COVID-19 declaration of emergency, whichever is longer. (42 C.F.R. § 455.434); Following this temporary enrollment, DHS will complete the complete enrollment process, including conducting a criminal background check, within 90 days of this temporary enrollment.

2.3 Waive site visits to temporarily enroll a provider for ninety (90) days or until the termination of the novel COVID-19 declaration of emergency, whichever is longer. (42 C.F.R. § 455.432).

2.4 Cease revalidation of providers who are enrolled with Wisconsin Medicaid or otherwise directly impacted by the emergency for ninety (90) days or until the termination of the novel COVID-19 declaration of emergency, whichever is longer.

2.5 Waive the 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 are enrolled with Medicare (42 C.F.R.§ 455.412).

2.6 Allow providers to receive payments for services provided to affected beneficiaries in alternative physical settings, such as mobile testing sites, temporary shelters or other care facilities, including but not limited to, commandeered hotels, other places of temporary residence, and other facilities that are suitable for use as places of temporary residence or medical facilities as necessary for quarantining, isolating or treating individuals who test positive for COVID-19 or who have had a high-risk exposure and are thought to be in the incubation period or to expand overall capacity to meet high demand.

3. Service Authorization and Utilization Controls. Wisconsin DHS is requesting that DHHS grant temporary authority to:

3.1 Waive prior authorization requirements for accessing covered State plan and/or waiver benefits (for example outpatient drugs pursuant to 42 U.S.C. § 1396r–

8(d)(5)). Circumstances include but are not limited to: relocation or isolation of BadgerCare beneficiaries; inaccessibility of resources provided by the facilities; relocation, reassignment, or isolation (due to illness) of pharmacy staff, primary care prescribers and staff, and/or specialty prescribers and staff in the affected areas.

4. **Benefits Flexibilities.** Wisconsin DHS is requesting that DHHS grant temporary authority to:

   4.1 Suspend cost sharing for all Wisconsin Medicaid participants for the duration of the declared emergency.

   4.2 Broadly waive any face-to-face requirements.

   4.3 Allow the authority to provide nutritional services including healthy meals for families and caregivers who may not have access to meals during the interrupted period of social distancing.

   4.4 Recognize any COVID-19 testing and related treatment of a Medicaid beneficiary outside of an emergency room setting as constituting "emergency services" or services for an "emergency medical condition" for purposes of various Medicaid requirements including, but need not be limited to, 42 U.S.C. § 1396u-2(b)(2) and 42 U.S.C. § 1396b(v)(2)-(3).

   4.5 Allow non-emergency ambulance suppliers and non-enrolled NEMT providers to be reimbursed at the applicable state FMA and waive the requirement that NEMT be provided by the least costly manner.

   4.6 Expand the authority under 1905(a) non-emergency transportation to allow for reimbursement of any Medicaid eligible individual, additional NEMT vendors, transportation for caregivers going to provide services to Medicaid members, allowing reimbursement for family members to travel with a Medicaid member to an appointment, and meal delivery to Medicaid members.

5. **Administrative Flexibilities.** Wisconsin DHS is requesting that DHHS grant temporary authority to:

   5.1 Waive public notice requirements that would otherwise be applicable to state plan and waiver changes. These requirements may include those specified in 42 C.F.R. § 440.386 (Alternative Benefit Plans), 42 C.F.R. § 447.57(c) (premiums and cost sharing), and 42 C.F.R. § 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

   5.2 Modify the tribal consultation timelines specified in the Wisconsin Medicaid state plan, to allow for consultation at the next future Tribal Health Director meeting.

Tribal Health Director meetings are scheduled to occur in odd numbered months.

5.3 Modify the requirement to submit the state plan amendment (SPA) by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. § 430.20.

5.4 Simplify program administration by allowing for temporary state plan flexibilities, such as lifting benefit limits, applying targeted rate increases for certain providers, rather than requiring the states go through the SPA submission and approval process. The State will memorialize the temporary State Plan changes in formal documentation submitted to CMS.

5.5 Waive timely filing requirements for billing under 42 U.S.C. § 1396a(a)(54), 42 U.S.C. § 1395cc, and 42 C.F.R. § 424.44 that will allow time for providers to implement changes to correct coding and other structural pieces built into their systems and even payer ability to adjudicate.

5.6 Waive timelines and grant leeway for all reports, required surveys, notifications, and licensing visits.

5.7 Allow Wisconsin Medicaid to extend managed care or subcontractor contracts and rates for contract and rate periods that are up for renewal during the declaration of emergency.

5.8 Allow suspending the application of the Emergency Medical Treatment and Active Labor Act (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).

5.9 Waive HIPAA electronic data interchange (EDI) code set requirements to provide 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 to allow Wisconsin to track and set rates for services specific to COVID-19.

5.10 Allow managed care enrollees to proceed almost immediately to a state fair hearing without having a managed care plan resolve the appeal first by permitting the state to modify the timeline for managed care plans to resolve appeals to one day so the impacted appeals satisfy the exhaustion requirements.
Give enrollees more than 120 days (if a managed care appeal) or more than 90 days (if an eligibility for fee-for-service appeal) to request a state fair hearing by permitting extensions of the deadline for filing those appeals by a set number of days (e.g., an additional 120 days).

6. **Eligibility Flexibilities.** Wisconsin DHS is requesting that DHHS grant temporary authority to:

    6.1 Expand Hospital Presumptive Eligibility to include the over 65/aged & disabled population. With the onset of COVID-19 in Wisconsin, the need to expand this benefit to some of the more vulnerable populations has become necessary. Through the 1135 waiver authority, the state seeks to expand its HPE populations to include individuals over the age of 65, blind, and/or disabled by ensuring that the most vulnerable of individuals have access to care.

    6.2 Waive requirements for periodic renewal of eligibility outlined in 42 C.F.R. § 435.916 in order to postpone the processing of annual Medicaid eligibility renewals for all Medicaid members that are scheduled to occur during the novel COVID-19 emergency declaration. This waiver may include suspension of all post-eligibility periodic data checks for unemployment, SWICA, TALX, and other sources. This also includes suspension of adverse actions to respond to changes in any eligibility factors, including, but not limited to, income and age.

    6.3 Allow flexibility under 42 C.F.R. § 435.912(e)(2) to allow the department to optimize the allocation of resources between eligibility determinations and other service delivery.

    6.4 Waive patient liability and long-term cost share requirements.

    6.5 Waiver CMS Payment Error Rate Measurement (PERM) and Quality Control (QC) requirements to allow some flexibility regarding errors during the duration of the declared emergency.

    6.6 Allow flexibility for the submission of electronic signatures on behalf of a member by application assistors if a signature cannot be captured in person. This would be in the case of individuals who are non-merit staff assisting individuals through the application process over the phone (who normally would be doing this assistance in-person)**.**

7. **Managed Care Flexibilities for Acute and Primary and Long-Term Care Health Maintenance Organizations (HMOs), Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).** Wisconsin DHS is requesting that DHHS grant temporary authority to:

    7.1 Waive the managed care network adequacy requirements under 42 C.F.R. §§ 438.68 and 438.207 for the duration of the declared emergency.

    7.2 Waive MCO requirements to complete initial and periodic re-credentialing of network providers, as long as the providers meet WI Medicaid provider enrollment requirements during the declaration of emergency.

7.3 Permit managed care organizations to email or text members without a written consent or opt-in for COVID-19 related education.

7.4 Require managed care organizations to extend pre-existing authorizations through which a beneficiary has previously received prior authorization through the termination of the emergency declaration.

8. Adult Long-Term Care/Home and Community Based Services Flexibilities.
Wisconsin DHS is requesting that DHHS grant temporary authority to:

8.1 Allow the State to freeze enrollment or eligibility changes based on a completed functional screen resulting in a change in level-of-care; or extend existing functional eligibility determinations.

8.2 Allow the State to extend the certification period of level-of-care screeners (LTCFS).

8.3 Allow the State to expand the list of services which family members, caregivers, or legally responsible individuals can provide to members.

8.4 Allow the State to briefly shelter participants at non-certified/licensed facilities.

8.5 Allow the State to waive participant liability for room and board when temporarily sheltered at non-certified/licensed facilities.

8.6 Allow the State to waive signature requirement on all LTC waiver program documentation, including level of care evaluations and plans of care updates, and allow for signature to be substituted with participant verbal attestation or other State-permitted means.

8.7 Allow the State to waive requirements related to home and community-based settings in order to ensure the health, safety and welfare of affected beneficiaries under 42 C.F.R. § 441.301(c)(4).

8.8 Allow the State to waive 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 C.F.R. § 441(b)(1)(ii)).

8.9 Allow the State to waive requirements related to conflict of interest and person-centered plan development in order to enable sufficient provider capacity to serve affected beneficiaries.

8.10 Allow the State to waive 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.

8.11 Allow the State to limit enrollment or to reasonably triage access to needed long-term services and supports for affected beneficiaries (§ 1902(a)(8)).

8.12 Allow the State to vary services and service delivery methods in geographic regions as appropriate for affected beneficiaries (§ 1902(a)(1) and 1902(a)(17)).

8.13 Allow the State to restrict freedom of choice of provider (§ 1902(a)(23)(A)).

8.14 Allow the State to waive all mass mailing requirements with regards to any LTC waiver program documents and allow, if necessary, for mass mailings to be substituted with verbal communication.

8.15 Allow the State to waive LTC waiver service provider qualifications.

8.16 Allow the State to pay for LTC waiver services that are not documented in the LTC participant's individualized LTC person-centered plan.

8.17 Allow the State to waive service authorization requirements.

8.18 Allow the State to relax Notice of Action issuance requirements.

8.19 Allow the State to create, add to, and expand 1915(b)/(c) waiver services, which will be included in forthcoming Appendix K submissions.

8.20 Allow the state HMOs, MCOs and PIHPs to cover "in lieu of" services not currently identified within the HMO, MCO, and PIHP contracts. Services would be in lieu of currently covered 1915(b)/(c) waiver services.

9. Children's Long-Term Care/Home and Community Based Services Flexibilities. Wisconsin DHS is requesting that DHHS grant temporary authority to:

9.1 Allow CLTS to pay above the waiver rates for access to critical services, such as support and service coordination, specialized medical and therapeutic supplies, respite care, adaptive aids, assistive technology and communication aids, child care, and supportive home care.

9.2 Provide federal funding to County Waiver Agencies for any COVID19 related services to CLTS and wait list families, such as personal protective equipment, disinfection supplies, and emergency nutritional supplies.

9.3 Allow beneficiaries to receive fewer than one service per month for a period of up to one-hundred twenty (120) days without being subject to disenrollment.

10. Wisconsin DHS is also seeking temporary authority on behalf of our hospital providers to:

10.1 Discharge Planning. 42 C.F.R. § 482.43(a)(8), § 485.642(a)(8). Allow hospitals to 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.

10.2 Medicare Conditions of Participation (CoPs).

10.2.1 Physical Environment. 42 C.F.R. § 482.41; A-0700 et seq;

10.2.1.1 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.

10.2.1.2 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.

10.2.2 Patient Rights. 42 C.F.R. § 482.13. Waive enforcement of patient rights related to personal privacy, confidentiality orders for seclusion, and patient visitation rights.

10.2.3 Sterile Compounding. 42 C.F.R. § 482.25(b)(1) and USP 797. Allow face masks to 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.

10.2.4 Verbal Orders § 482.24, A-0407, A-0454, A-0457. Allow verbal orders to 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.

10.2.5 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.

10.2.6 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.

10.2.7 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.

10.3 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.

10.4 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.

10.5 Flexibility in Patient Self Determination Act Requirements. 42 C.F.R. § 489.102

10.6 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.

11. Wisconsin DHS is also seeking temporary authority on behalf of our nursing home providers to:

11.1 Frequency of Physician Visits. 42 C.F.R. § 483.30(c) (1)-(4). Waive the 30/60/90-day schedule requirement for in-person physician visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

11.2 Requirements for facility hiring and use of nurse aides. 42 C.F.R. § 483 (d)(1)-(3). Suspension of the 120 day limitation on CNA's who have not been able to take a test to become certified.

11.3 Medical Director. 42 C.F.R. § 483.70(h)(1)(2). 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.

11.4 Notice before transfer. 42 C.F.R. § 483.15(c)(3)-(6)(8). Waive notice of transfers within the facility due to medically necessary protection of COVID-19. (To separate ill and well residents within the facility)

11.5 Orientation for transfer or discharge. 42 C.F.R. § 483.15(c)(7). Waive requirement to document sufficient preparation and orientation to resident to ensure a safer and orderly transfer intra facility only. There may be a time when a resident needs to be moved immediately for their safety.

11.6 Bedhold policy. F625 483.15(d)(1)(2). Waive requirements for bedhold policy.

11.7 Regular in-service education. 42 C.F.R. § 483.35 (d)(7). Waive the requirement during this period due to the workforce reduction during the COVID crisis.

11.8 Nurse staffing. 42 C.F.R. § 483.35(g)(1)-(4). Waive nurse staffing information and posting of that information.

11.9 Drug Regimen Review. 42 C.F.R. § 483.45(c)(1)(2)(4)(5). Suspend pharmacist from going in monthly to facility to do record review. (From their office potentially).

11.10 Paid feeding assistants. 42 C.F.R. § 483.60(h)(1)-(3). Waive or lessen requirements for a program and set guidelines for training to assist with the COVID-19 crisis.

11.11 Maintenance reviews. 42 C.F.R. § 483.90. Waive the annual/quarterly screening of fire extinguishers or any other annual review of maintenance review during the COVID-19 concerns.

12. Wisconsin DHS is also seeking temporary authority on behalf of our nurse aide training and testing programs to:

12.1 42 C.F.R. § 483.152 (a)(3). Allow all clinical hours to be online simulation.

12.2 42 C.F.R. § 483.152. Waive the primary instructor qualifications in for approval of a nurse aide training and competency evaluation program.

12.3 42 C.F.R. § 483.151 (b)(2) Waive the loss of Nurse Aide Training and Competency Evaluation Program (NATCEP)

12.4 42 C.F.R. § 483.160 Waive the requirements for training of paid feeding assistants.

12.5 42 C.F.R. § 483.35(d)(1) Allow a facility to use individuals longer than 4 months without being enrolled in an approved training and competency evaluation program.

13. Wisconsin DHS is also seeking temporary authority on behalf of our home health agencies to:

13.1 42 C.F.R. § 484.55(a). Allow home health agencies to perform certifications, initial assessments and determine patients' homebound status remotely or by record review.

14. Wisconsin DHS is also seeking temporary authority to waive the following Life Safety Codes on behalf of our hospitals, hospices, nursing homes, intermediate care facilities for individuals with intellectual disabilities, and critical access hospitals:

14.1 42 C.F.R. § 482.41 Hospitals

14.2 42 C.F.R. § 483.90 Nursing homes

14.3 42 C.F.R. § 483.470 Intermediate Care Facilities for individuals with intellectual disabilities

14.4 42 C.F.R. § 485.623 Critical Access Hospitals

14.4.1 Section 9.6.1.5 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program. NFPA 101 2012

14.4.2 Section 9.7.5 All automatic sprinkler and standpipe systems required by this *Code* shall be inspected, tested, and maintained in accordance with NFPA 25.

14.4.3 Section 9.7.4.1 Portable fire extinguishers shall be inspected, and maintained in accordance with NFPA 10.

Thank you for the prompt consideration of Wisconsin's request.
Sincerely,

Jim Jones
Medicaid Director
Division of Medicaid Services
Wisconsin Department of Health Services

cc: Andrea Palm, WI DHS
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