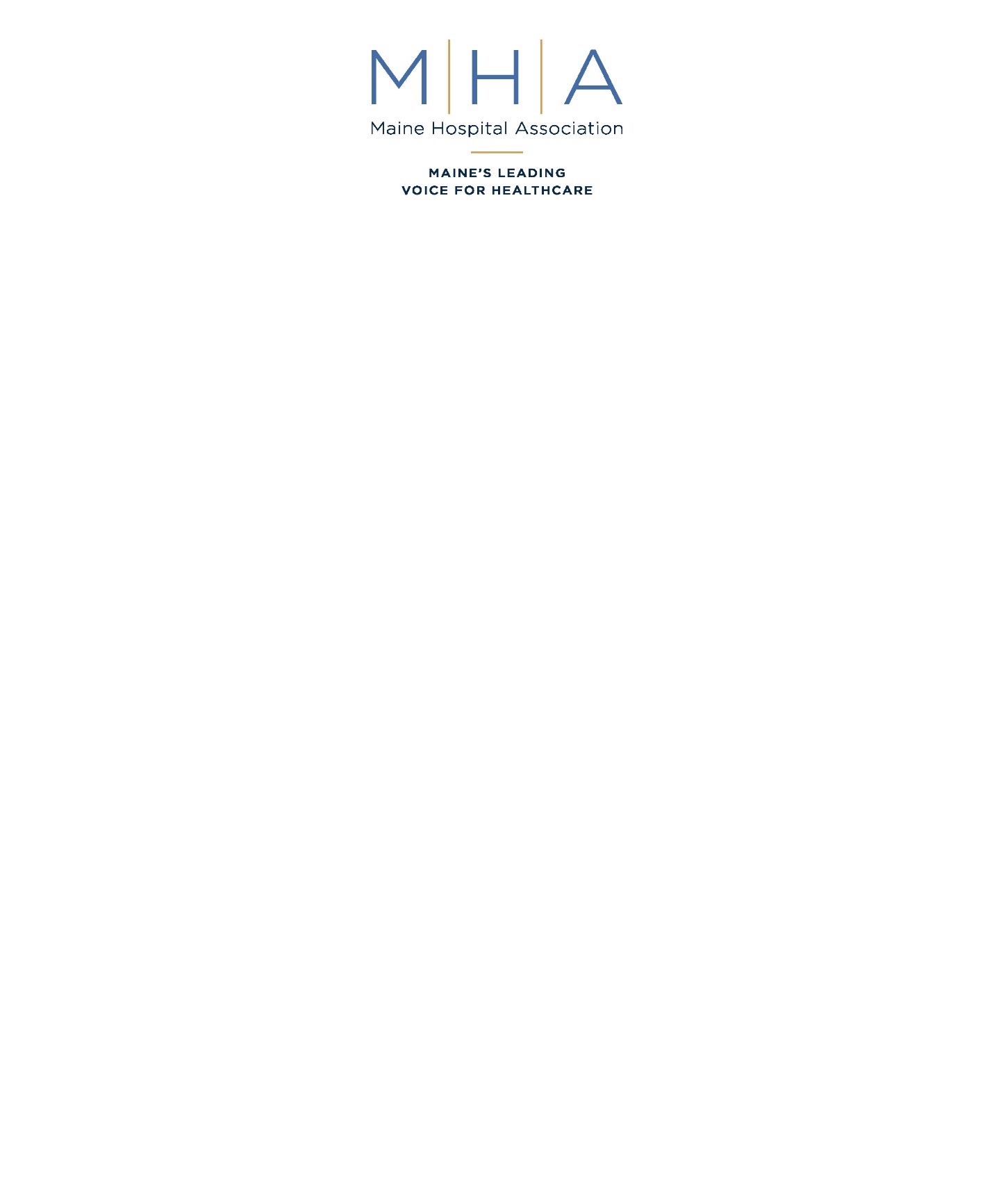
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**Hospital-Related Waivers**

**4 / 17 / 20**

**Fed waivers are in green;**

**State waivers are in blue**

**If waiver has been granted, link to it is embedded in granted date;**

**If waiver has only been requested, link to it is embedded in requested date.**

**UPDATE 4/17/20**

* **#8 – CMS: Additional Blanket Waivers Granted**
* **#18 – MHDO: Partial Extension of MHDO Data Submission Deadlines Granted**
* **#21 – Governor: MHA & Others Request Liability Protection**
* **#22 – DHHS: Licensing Guidance on How to Add Bed Capacity for Either Hospitals or NFs**

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|  | **Granted By / When** | **Summary** | |
| 1 | **CMS 1135 /** [**3-30-20**](https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)  (This link is now to the updated 4/15/20 document.)  This MASTER SUMMARY includes both:  The first DHHS“[BLANKET](https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf)”  1135 waiver of[**3-13-20**](https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx)  AND  It also includes the “ASSOCIATION TEMPLATE” 1135 waiver of [**3-28-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Approved-Association-Waivers-(3-28-20).aspx)  that MHA and over a dozen other states received.  It also included many new waivers as well.  **State Note 1**:  DHHS Licensing issued a [letter](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/DLR-Letter-to-all-Hospitals-(3-25-20).aspx) on 3-27-20 (dated 3-25-20) dealing with the topics in the original CMS “blanket” waiver of 3-13-20 indicating:  *“There are no conflicts between the blanket 1135 waivers issued by the federal government and the Hospital Licensing Rules under…DLC authority. Therefore, hospitals may comply with the federal waiver and do not also need to submit a separate waiver request of DLC.”*  **State Note 2:**  As indicated by an “\*” in the bullet list, some of the 1135 waivers are only effective “*so long as it is not inconsistent with a state’s emergency preparedness or pandemic plan*.”  We are working with DHHS on this.  **State Note 3:**  Some of the issues waived may have a state statutory and/or regulatory provision that needs Governor waiver (for example, we have state law limiting CAH hospitals to 25 beds).  MHA has sought one statutory waiver (for the 25-bed limit) and kinda received one for the regulatory cap (see “[letter](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/DLR-Letter-to-all-Hospitals-(3-25-20).aspx)”).  We don’t yet know what other statutory or regulatory waivers might be necessary. | **“MASTER SUMMARY”**  **HOSPITALS**   * **Emergency Medical Treatment and Active Labor Act (EMTALA).** \* * **Verbal Orders**. * **Reporting Requirements**. * **Patient Rights**. * **Sterile Compounding**. * **Detailed Information Sharing for Discharge Planning for Hospitals and CAHs**. * **Discharge Planning for Hospitals**. * **Medical Staff**. * **Medical Records**. \* * **Flexibility in Patient Self Determination Act (Advanced Directives).** * **Physical Environment**. \* * **Telemedicine** * **Physician Services** \* * **Anesthesia Services** \* * **Utilization Review** \* * **Emergency Services (Surge Facilities Only)** \* * **Emergency Preparedness Policies** * **Quality Assessment and Performance Improvement Plan** \* * **Nursing Services in Hospitals** \* * **Food Services** \* * **Respiratory Care Services** \* * **CAH Personnel Qualifications** \* * **CAH Staff Licensure** \* * **CAH Status and Location** \* * **CAH Length of Stay** * **Temporary Expansion Locations** * **Housing Acute Care Patients in IRF (Distinct Unit Parts)** * **Care for Excluded Inpatient Psych Unit Patients in the Acute Care Unit of a Hospital** * **Care for Excluded Inpatient Rehab Uni Patients in the Acute Care Unit of a Hospital** * **Flexibility for Inpatient Rehab Facilities Regarding the “60% Rule”** * **Extension for IPPS Wage Index Occupational Mix Survey Submission**   **LTCH**  **Neoplastic Disease Care Hospitals**  **LONG-TERM CARE AND SNF**   * **3-day hospitalization** * **Reporting Minimum Data Sets** * **Staffing Data Submission** * **PASSR** * **Physical Environment** \* * **Resident Groups** * **Training and Certification of Nurses Aides** * **Physician Visits in SNF/NF** * **Roommates and Grouping** * **Transfer and Discharge** \*   **HOME HEALTH**   * **Anticipated Payments** * **Reporting** * **Initial Assessments** * **Waive Onsite Visits for HHA Aide Supervision**   **HOSPICE**   * **Volunteers** * **Comprehensive Assessments** * **Non-Core Services** * **Onsite Visits for Hospice Aide Supervision**   **ERSD**  **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)**  **Practitioner Locations**  **Provider Enrollment**  **Medicare Appeals in FFS and MA and Part D**  **Medicaid and Chip (as of 3/13/20)**  **Stark Law (Guidance** [**here**](https://www.cms.gov/files/document/covid-19-blanket-waivers-section-1877g.pdf)**.)** | |
| 2 | **CMS 1135 /** [**3-17-20**](https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)   * **Medicare Telehealth**   **Note:**  MHA staff is not sure if the telehealth provision in the CMS Master Summary document above covers all of the topics in the 3-17-20 waiver so we kept it in this table. | Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020.  A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.  Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. | |
| 3 | **CMS 1135 /** [**4-7-20**](https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/90996) | **Maine DHHS** / [4-2-20](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/1135_ME-4-2-20.aspx) (one-pager [here](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Final-1135-Waiver-Overview-4-6-2020.aspx))  The waiver was applied for by the Office of MaineCare Services. It was partially granted on 4-7-20; only the standard “checkbox” list of issues was approved, the additional waiver requests are still under review.  **Checkbox Items**  **Reduce Prior Authorizations**  • Suspend certain fee-for-service prior authorization requirements, including for asthma and immunerelated drugs  • Extend certain pre-existing authorizations, including for prescriptions and certain durable medical equipment  **Streamline Provider Enrollment**  • Waive payment of application fee, site visits, and certain quality assurance activities to temporarily enroll a provider  • Permit providers located, enrolled and/or licensed out-of-state to provide care to members and be reimbursed  • Postpone deadlines for revalidation  **Improve Hospital and Nursing Facility Capacity and Flexibility**  • Suspend Pre-Admission Screening and Resident Review (PASRR) Level I and II Assessments for 30 days, in order to ensure hospitals can more quickly discharge members to nursing facility placements as appropriate  • Allow existing providers to provide services in alternative settings, including an unlicensed facility, in order to respond to the CVID-19 emergency.  **Additional Items (Not Yet Approved as of 4-7-20)**  1. Provide Flexibility to Temporarily Delay Scheduling of Medicaid Fair Hearings and Issuing Fair Hearing Decisions during the Emergency Period.  2. Waiver of Required Certification Timelines for Qualified Staff.  3. Waiver of Certain Staffing and Staff Qualification Requirements.  4. Waiver of Opioid Treatment Program (OTP) Take-Home requirements.  5. Public Notice and Tribal Consultation.  6. Co-payments and Premiums.  7. Alternative Setting.  8. Permit Receiving (provider) Site Services via Telehealth for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). | |
| 4 | **CMS 1135 / REJECTED**  **3-31-20** | **MHA** / [**3-30-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/CMS-Waiver-Request-March-2020-18675.aspx)  CMS has indicated that it has granted all the association waivers it is going to grant, for now (we believe states may still receive waivers). | |
| 5 | **CMS /** [**3-22-20**](https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting)  **Note:**  MHA staff believes this waiver is not captured in the CMS Master Summary. | **Quality Data Reporting**  CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs.  The action comes as part of the Trump Administration’s response to 2019 Novel Coronavirus (COVID-19).  CMS guidance [here](https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf) and [here](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/QPP-COVID-19-Response-Fact-Sheet(3).aspx). | |
| 6 | **Congress /** [**3-27-20**](https://www.aha.org/system/files/media/file/2020/03/house-passes-the-coronavirus-aid%2C-relief%2C-and-economic-security-cares-act-bulltein-3-27-2020.pdf) | **Variety of Waiver-type Actions in Stimulus Package (AHA Summary)**  **Additional Post-acute Care Flexibilities.** The legislation provides flexibility for post-acute care (PAC) providers so they are able to increase the capacity of the health care system, without penalty, during the emergency period. This includes waiving:   * the inpatient rehabilitation facility (IRF) 3-hour rule, which requires that IRF patients generally receive at least three hours of therapy a day; * LTCH site-neutral payment policy, which uses an IPPS-level payment rate for lower-acuity patients; and * the LTCH “50% Rule,” which requires that greater than 50% of patients be paid a standard LTCH PPS rate for the hospital to maintain an LTCH designation.   **Home-based Services**. The bill makes a number of policy changes regarding the provision of home-based health care services, which seek to increase access and decrease patient risk during the emergency period.  Face-to-Face Visits between Home Dialysis Patients and Physicians. This provision will reduce requirements during the COVID-19 emergency that pertain to face-to-face evaluations for home dialysis patients.  Enabling Additional Health Professionals to Order Home Health Services. This provision will expand the ability of physician assistants, nurse practitioners and certified nurse specialists with regard to the certification of home health services and document-related requirements.  Facilitating Home and Community-based Support Services during Hospital Stays. This provision will expand certain state and community-based services guidelines to include self-directed personal assistance services and attendant services and supports. Many of these policy changes also will apply to Medicaid home health services.    **Telehealth.** The legislation will make a number of policy changes regarding the provision of telehealth services, which may increase access during the emergency period. These include:  Medicare Telehealth Flexibilities. This section will eliminate the requirement included in the Coronavirus Preparedness and Response Supplemental Appropriations Act (H.R. 6074) that providers or others in their group must have treated the patient in the past three years to provide them with a telehealth service during the ongoing public health emergency. The net result of this section and Section 102 of the Telehealth Services During Certain Emergency Periods Act of 2020 – a subpart of H.R. 6074 – will be to give the HHS Secretary authority to waive, among other policies, the geographic and originating site requirements of Section 1834(m) of the Social Security Act (the Act) as he sees fit, without restrictions on the definition of “qualified provider.”  Enhancing Medicare Telehealth Services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) during Emergency Period. Subject to a section 1135 emergency declaration, this legislation will waive the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as distant sites.  Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule.  Using Telehealth for Hospice Recertification. This section allows hospice recertifications to be completed via telehealth, rather than a face-to-face visit, during the emergency period.  **Sharing of Substance Use Disorder Records with Patient Consent.** This section will allow records pertaining to substance use disorder (SUD) treatment or other activities to be used or disclosed to covered entities for the purposes of treatment, payment or health care operations as permitted by HIPAA once a patient’s written consent has been obtained. It also will allow disclosures of de-identified health information from these records to public health authorities as defined by HIPAA. The section will prohibit the use of this information for use in any civil, criminal, administrative or legislative proceedings (except as otherwise authorized), and contains an antidiscrimination clause ensuring that the information may not be used in decisions around treatment, employment, housing, access to courts or social services. Patients still will have the right to request restrictions on the use or disclosure of their SUD treatment records. Finally, this section will require an update to the regulations in no less than one year so that covered entities will be required to provide notice in plain language on their privacy practices to patients. | |
| 7 | **CMS 1135 /** | **AHA /** [**4-6-20**](https://www.aha.org/system/files/media/file/2020/04/aha-urges-hhs-to-temporarily-suspend-certain-requirements-for-health-care-providers-4-6-2020.pdf)  **Laundry list - 7 pages of requests.** | |
| 8 | **CMS 1135 /** [**4-8-20**](https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)  (This link is now to the updated 4/15/20 document.)  **Note 1:** The new waivers were added to the massive blanket document that CMS issued 3-30-20 (#1 above).  **Note 2:** Like all other CMS waivers, we need clarity on whether there are any mirror state-level statutes or regulations that need to be waived. | **Additional Blanket (**[**Press Release**](https://www.cms.gov/newsroom/press-releases/trump-administration-acts-ensure-us-healthcare-facilities-can-maximize-frontline-workforces-confront)**)**  According to AHA, CMS is:  **Waiving the requirement that critical access hospitals (CAHs) have a physician physically present to provide medical direction, consultation and supervision.**    **Waiving the requirement that a nurse practitioner, physician assistant or certified nurse-midwife be available to furnish patient care services at least 50% of the time a rural health clinic (RHC) or federally qualified health center (FQHC) operates.**   **Waiving the requirement that physicians must provide medical supervision of nurse practitioners at RHCs and FQHCs, to the extent permitted by state law.** CMS    **Waiving regulations that prevent a physician at a long-term care facility from delegating a task when the regulations specify that the physician must perform it personally.** Any task delegated under this waiver must continue to be under the supervision of the physician, and may not be delegated when prohibited under state law or by the facility's own policy.  **Waiving the requirement that all applicable required physician visits at a long-term care facility be made by the physician personally.**    **Waiving the requirement that home health agency (HHA) occupational therapists (OTs) may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care.**    **Waiving the requirements that a nurse conduct an onsite supervisory visit every two weeks for patients under HHA care.**    **Modifying the requirement that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient.**    **Waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period.** | |
| 9 | **Super of Insurance /**  [**3-19-20**](https://www.maine.gov/pfr/insurance/covid19_cornoavirus/pdfs/Insurance%20Emergency%20Response%20Order%20re%20Credentialing%203-19-2020.pdf) | **BOI - Credentialing**  Credentialing: Health care organizations with multiple locations might operate under one corporate organizational structure, but health carriers might require providers to be separately credentialed at each location where they work. The effect is that the organizations cannot send their providers where they are most needed because of emergent conditions, such as those associated with the COVID-19 emergency, and submit payable claims to health carriers for their providers’ services. Therefore, for the duration of this emergency, health carriers shall not refuse, because of lack of credentials, to pay claims submitted by providers credentialed within a health care organization but not at that health care organization’s location where the service was provided or at a location not in that health care organization. A carrier may establish reasonable notice requirements if a provider is reassigned to a different location in the same or another health care organization. However, there must be a reconciliation process to ensure that claims submitted by or on behalf of credentialed providers will not be denied indefinitely on the ground that the provider’s credential is not valid at the location where the service was provided. | |
| 10 | **Super of Insurance /**  [**3-20-20**](https://www.maine.gov/pfr/insurance/covid19_cornoavirus/pdfs/Insurance%20Emergency%20Response%20Order%20re%20Telehealth.pdf) | **BOI - Telehealth**  Remote Delivery of Health Services: In my March 12 order, I noted the importance of telehealth during this crisis, reminded carriers that 24-A M.R.S. § 4316 requires parity between coverage of telehealth and in-person services, and directed them to review their telehealth programs with participating providers to ensure that the programs are robust and will be able to meet any increased demand. However, the statutory definition of “telehealth,” 24-A M.R.S. § 4316(1)(C), expressly excludes, among other methods, “the use of audio-only telephone.” Audio-only telephone communication is often a necessary tool to provide effective remote access for patients. The Centers for Medicare and Medicaid Services has already taken measures to modify applicable federal privacy standards to accommodate this need. I am therefore ordering that in addition to telehealth as defined in the Insurance Code, carriers must also provide parity in coverage for other clinically appropriate remote delivery of medically necessary health care services, including office visits conducted by non-public-facing telephone communication methods that have audio-only or audio-video capability, to the extent that the provider is permitted by law to provide such services. All carriers are further ordered to ensure that rates of payment to in-network providers for services delivered via telehealth and other remote modalities are not lower than the rates of payment established by the carrier for services delivered in person, and to notify providers for any instructions necessary to facilitate billing for such remote services. | |
| 11 | **Super of Insurance /**  [**3-12-20**](https://www.maine.gov/tools/whatsnew/index.php?topic=INS-Bulletins&id=2220066&v=boi-template2017) | **Bulletin 442**  **First-Dollar Coverage of COVID-19 Screening and Testing:** To ensure that cost does not create a barrier for consumers receiving medically necessary screening and testing for COVID-19, I direct all health insurance carriers to make these services available with no deductible, copayment, or other cost sharing of any kind, or any prior authorization requirement, including all associated costs such as processing fees and clinical evaluations. I appreciate the proactive measures taken by those carriers that are already doing so on their own initiative. Patients may be encouraged to visit their primary care practitioners or other network providers for screening visits, but the only situation in which carriers will be permitted to impose out-of-network charges is when the enrollee was offered the service in-network without additional delay but chose instead to visit an out-ofnetwork provider or be tested by an out-of-network laboratory**.**  **Immunizations:** If and when an immunization becomes available for COVID-19, carriers shall immediately cover the cost of the vaccine and all associated costs of administration without cost sharing, on the same basis as screening and testing services.  **Emergency Care:** Carriers are reminded that Maine law requires coverage of emergency services, with network-level cost-sharing regardless of the status of the emergency provider, whenever a prudent layperson, possessing an average knowledge of medicine and health, would believe that immediate medical attention is necessary to avoid serious jeopardy to health, serious impairment of a bodily function; or serious dysfunction of any organ or body part. Prior authorization may not be required for emergency services.  **Network Adequacy:** A pandemic has the potential of creating multiple strains on the health care system. At the same time that demand for services increases, the supply is reduced, both because providers are occupied with high patient loads and because practitioners themselves might be ill or under quarantine. Health carriers need to be prepared for the likelihood that their networks could be overloaded from time to time. If this happens, they are required by Bureau of Insurance Rule 850, § 7(B)(5), to ensure that the covered person’s cost to obtain the covered benefit is no higher than if the benefit were obtained from participating providers, or to make other arrangements acceptable to the Superintendent. Likewise, when patients are treated at in-network facilities, they must be protected from surprise billing by out-of-network providers, as required by 24-A M.R.S. § 4303-C.  **Telehealth:** Telehealth services can mitigate the impact of the disruptions to health care delivery. Furthermore, because COVID-19 is a communicable disease, some enrollees might choose to use telehealth services instead of in-person health care services, or might be under restrictions that limit their ability to visit providers in person. Health carriers are reminded that 24-A M.R.S. § 4316 requires parity between coverage of telehealth and in-person services, and are directed to review their telehealth programs with participating providers to ensure that the programs are robust and will be able to meet any increased demand**.**  **Access to Prescription Drugs:** If supply chain disruptions result in shortages of medications that are on a carrier’s formulary, the carrier must act promptly to make substitutes available when necessary, at no greater cost to the patient and without imposing prior authorization or step therapy requirements. Carriers shall also allow enrollees to obtain one-time refills of their prescription medications before the scheduled refill date, so that enrollees are assured of maintaining an adequate supply. Exceptions may be made for drug classes subject to misuse, such as opioids, benzodiazepines, and stimulants.  **Utilization Review:** When dealing with limited resources or unusual demand, carriers must prioritize the timely delivery of medically necessary health care services to enrollees. Both for services related to COVID-19 and also for any other care that their enrollees might need, carriers must conduct any applicable utilization review and appeal processes as expeditiously as possible, including but not limited to compliance with the requirements of the Health Plan Improvement Act and Rule 850.  **Communication:** Access to accurate information and avoiding misinformation are critical. Carriers shall give prompt notice to enrollees, providers, and the public of the measures they are taking to respond to the COVID-19 threat, including but not limited to measures taken to comply with the terms of this order. They shall ensure that the information is updated on an ongoing basis to remain current and correct. In particular, carriers must provide clear and prominent notice that they are waiving cost-sharing for medically necessary screening and testing for COVID-19, guidance on how enrollees can access such care, and notice that they are permitting early prescription refills. This notice must be posted prominently on the carrier’s Web site, provided to all customer service personnel and all nurse help-lines and similar programs, and communicated to all network providers and facilities. Carriers shall provide the Bureau with copies of all notices**.** | |
| 12 | **Super of Insurance / REJECTED** | **MHA** / Denial of Payment Issues/Force Majeure  **Update**: *It appears BOI may not have much authority to override contract terms between providers and carriers. However, they are interested in hearing from providers if the COVID disruptions are causing administrative challenges for hospitals viz. securing prior authorization or timely billing. They have offered to hear those concerns and carry them forward to carriers on our behalf.* | |
| 13 | **Governor /** [**3-20-20**](https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/EO%2016%20An%20Order%20Suspending%20Provisions%20of%20Certain%20HC%20Professional%20Licensing.pdf)  **EO 16**  **Licensing** | **BOLIM**  Allowing licensed physicians, physician assistants, and nurses greater flexibility to contribute to Maine's response during the civil state of emergency. Those who are licensed and in good standing in other states can now:   * Receive an emergency license to provide health care in person or through telehealth to Maine people, with no application fee * See Maine patients through telehealth without obtaining a Maine license, if already serving those patients at out-of-state locations * Have their licenses automatically renewed if up for renewal during the state of emergency * Suspend conforming to physician oversight requirements (for physician assistants and advanced practice registered nurses) * Reactivate their license immediately with no application fee, if retired.   Additionally, all physicians, physician assistants and nurses licensed in Maine and those authorized under the order may provide services through all methods of telehealth, including video, audio and other electronic technologies to treat Maine people for all medical needs. The order expands acceptable technologies beyond only those that are compliant with patient privacy laws, to align Maine with major changes made by the federal government that provide broad coverage for telehealth services for Medicare members. | |
| 14 | **Governor /** [**4-7-20**](https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/EO%2035.pdf)  **EO 35**  **Licensing / Telehealth** | **This order essentially takes EO 16 above and extends its provisions to all health care licensees including respiratory care practitioners and:**  psychologists, psychological examiners, clinical social workers, clinical professional counselors, pastoral counselors, marriage and family therapists, alcohol and drug counselors, physical therapists, physical therapy assistants, chiropractic doctors, pharmacists, pharmacy interns, pharmacy technicians, podiatrists, occupational therapists, occupational therapy assistants, speech-language pathologists, hearing aid dealers and fitters, audiologists, certified interpreters, certified deaf interpreters, limited interpreters, and limited deaf interpreters, athletic trainers, naturopathic doctors, acupuncturists, dietitians, radiologic technologists and certified professional midwives | |
| 15 | **Governor /** | **MHA** / [3-25-20](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Letter-to-the-Governor-March-2020-(002).aspx) “EARLY BLAST”  Laundry List of Issues  **Note**:  *May not be an effective request because it did not conform to state format*. *So, we started doing individual requests on March 26. May not make individual request for everything in the blast.* | |
| 16 | **Governor (DHHS) /** | **MHA** / [3-26-20](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Waiver-Request-Form-(MHA-CAH)-18553.aspx) | **CAH**   * Waive state laws on 25 bed limit and 96 hour limit.   **Update**:  DHHS believes a waiver of statute is not necessary and they are finalizing a process to increase bed capacity. We are waiting for something in writing on this. |
| 17 | **Governor (PFR) / APPROVED** | **MHA** / [**3-26-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Waiver-Request-Form-(MHA-MHDO)-18552.aspx) | **Respiratory Therapist**   * Add RT to Governor’s EO 16   **In EO 34 (#13 above)** |
| 18 | **Governor (MHDO) / APPROVED**  **4-14-20** | **MHA** / [**3-26-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Waiver-Request-Form-(MHA-MHDO)-18552.aspx) | MHDO partially granted our request. MHDO will send out official notice shortly**.**   Please do not hesitate to contact MHDO with any questions at [Karynlee.Harrington@maine.gov](mailto:Karynlee.Harrington@maine.gov).   1. **Hospital Quality Data (chapter 270)**:  MHDO will suspend enforcement of the current deadlines described in Rule Chapter 270.  All quality data periods as described in the table above will need to be submitted to the MHDO by January 30, 2021.  Note:  MHDO will accept data from hospitals that are in a position to report data to the MHDO as usual.    1. **MHDO will suspend the enforcement of the new reporting requirement on hospitals** effective early 2020 specific to the surgical site infection rates for patients undergoing inpatient knee and hip prosthesis for one year.  Revised start date January 2021. 2. **Hospital Financial Data (chapter 300):**     1. **MHDO Hospital Financial Template:**  MHDO will suspend enforcement of the current deadline described in Rule Chapter 300 for the submission of the MHDO hospital financial templates.  MHDO will extend the reporting deadline for the financial templates for hospitals with due dates in 2020, to January 30, 2021.   Note:  MHDO will accept data from hospitals that are in a position to report data to the MHDO as usual.    2. **Audited Financial Statements**:  MHDO will suspend enforcement of the current deadline described in Rule Chapter 300 for the submission of the hospitals audited financial statement.  MHDO will extend the reporting deadline for the audited financial statements for hospitals with due dates in 2020, to October 31, 2020 (exception is for the 6/30 FYE date; due date is 12/31/20).   Note:  MHDO will accept data from hospitals that are in a position to report data to the MHDO as usual. 3. **Hospital Baseline Organizational Data (chapter 300):**  MHDO will suspend enforcement of the current deadline described in Rule Chapter 300 for the hospital review and annual update of the baseline organizational data.  The annual review and update of the baseline information will be required by April 30, 2021. 4. **Hospital Inpatient and Outpatient Encounter Data (chapter 241):**  Both the private and public sectors rely on access to the hospital encounter data that the MHDO collects from hospitals to understand patterns, trends, at risk populations, demographics, resource allocation etc.  In fact, a few days ago there was an inquiry from one of Maine’s Healthcare Systems re MHDO’s ability to assist the hospital with their data needs specific to COVID 19 based on the hospital data that the MHDO collects and organizes for release.  Extending  the submissions deadlines of this critical data set at this time will create significant delays in the release of the MHDO hospital data that may have unintended consequences in the ability to use this data to drive change.   MHDO will work with any hospital that is having difficulty meeting the reporting deadlines as described in Rule Chapter 241. |
| 19 | **Governor /** | **MHA** /  (In Process) | “Yellow Flag” |
| 20 | **Governor (DOL) /** | (In Process) | Reporting and penalty issues. |
| 21 | **Governor /** | **MHA & Others** /  [4-9-20](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/Providers-Waiver-Request-Liability-Protection-(4-9.aspx) | **Liability** – Criminal, Civil & Professional |
| 22 | **DHHS / 4-7-20** | **MHA** | **Bed Capacity / CON**  Division of Licensing Issued Guidance on Adding Bed Capacity:   * [Overview](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/CON-information-form-(Hosp-NH)-4-7-2020_.aspx), * Hospital [Form](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/CON-Request-form-hospital-4-7-2020.aspx), * Nursing Home [Form](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/CON-Request-Form-NH-4-7-2020.aspx). |
| 23 | **DHHS /** [**3-20-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/DHHS-Emer-Rule-(3-20-20).aspx)   * **Prior Authorization** * **Co-Pays** * **Other** | **MaineCare**  The Department is waiving co-payments for some MaineCare services for all MaineCare members. Co-payment waivers cover pharmacy, clinical visits, medical imaging, laboratory services, behavioral health services, medical supplies and durable medical equipment, private duty nursing, and home health services. Should COVID-19 specific treatments and/or vaccines become available during the duration of this rule, co-payments will be waived for those services as well.  The Department is altering some of the MBM, Section 80, Pharmacy Services, requirements in order to expedite and improve access to prescriptions. Restrictions are lifted for asthma and immune-related prescriptions.  Prior Authorizations for COVID-19 treatments and/or vaccines, should they come available, are waived. Early refills of prescriptions are allowed, and the physical assessment requirements for Buprenorphine and Buprenorphine Combination products for SUD are waived.  Prior Authorization requirements for certain durable medical equipment are being extended and early refills allowed for individuals with COVID-19, awaiting test results for COVID-19, or in the high-risk category for developing complications from COVID-19.  Home Health Services document submission requirements are being extended for Plans of Care submissions.  The Department is waiving the advance written notice/consent for telehealth services, waiving the comparability requirement for services specifically approved by the Department, and allowing the provision of telephone-only evaluation and management services for members. | |
| 24 | **DHHS** / [**3-16-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/DHHS-Telehealth-Emer-Rule-(3-16-20).aspx)   * **Telehealth** | **MaineCare**  This emergency rulemaking will remove the MaineCare Benefits Manual (MBM), Chapter I, Section 4, Telehealth Services blanket prohibition against providers utilizing telehealth to deliver services under the MBM, Chapter II, Section 80, Pharmacy Services. Pursuant to 5 M.R.S. Section 8054, the Department has determined that immediate adoption of this rule is necessary to avoid a potentially severe and immediate threat to public health, safety or general welfare. The Department’s findings of emergency are set forth in detail in the Emergency Basis Statement. On March 11, 2020, the World Health Organization declared COVID-19 a worldwide pandemic. As a preemptive action by the Department, Pharmacy Services will be available via telehealth when medically necessary and appropriate. | |
| 25 | **DHHS /** [**3-25-20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/DLR-Letter-to-all-Hospitals-(3-25-20).aspx)   * **Hospital Licensing (Bed capacity)** | **Licensing**  In its letter noting that the “Blanket” CMS 1135 waiver is effective in Maine, DHHS also provided some additional “State Blanket” waivers.   * CAH - 25 bed & 96 hour (1.3) * Bed Capacity Requires DLC Approval (2.11) * Fee waived for temporary licenses (2.5.8.3) * Licenses don’t have to list max beds (2.9.4)   However, hospitals are still required to “request” additional bed capacity in a written application. | |
| 26 | **MISCELLANEOUS** | * **Maine:** Hospital Cafeteria Issue ([**3-23-20**](https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/documents/EatingEstablishmentExecutiveOrderQuestionsAndAnswers.pdf))   *Hospitals excluded from the restaurant shut-down; modify functions.*   * **Federal:** DOJ/FTC Statement on Antitrust ([**3-24-20**](https://www.ftc.gov/system/files/documents/public_statements/1569593/statement_on_coronavirus_ftc-doj-3-24-20.pdf)) * **Federal:** DOL Families First Guidance AHA Summary – **(**[**4/1/20**](https://www.aha.org/system/files/media/file/2020/04/dol-releases-faqs-on-families-first-coronavirus-response-act-employer-provisions-bulletin-4-1-2020.pdf)**)**   *Hospitals excluded from expanded family leave benefit*.   * **Maine: D**HHS Letter on Behavioral Health Topics – **(**[**4/3/20**](https://www.maine.gov/dhhs/oms/pdfs_doc/COVID-19/Behavioral-Health-Frequently-Asked-Questions-04032020.pdf)**) –** includes the verbal consent issue. * **Maine:** DHHS Letter to Nursing Homes on Variety of Topics **– (**[**3/20/20**](http://themha.org/policy-advocacy/Issues/Novel-Coronavirus-(2019-nCoV)/MHCA-COVID-19-LTC-Regulatory-Relief_-(003)-19509.aspx)**)** | |
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