March 23, 2020

Honorable Gavin Newsom
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Newsom:

The California Medical Association (CMA) appreciates your continued leadership to address the COVID-19 public health crisis in California and the decisive action your Administration has taken to curb the spread of the virus. CMA remains committed to working with you to identify immediate actions that your office can take through Executive Order or other mechanisms to address the spread of the disease. We must act quickly to ensure that our healthcare system can address the immense challenge ahead of us for caring for those that desperately need medical treatment including the State’s most vulnerable populations. We respectfully submit to you the following recommended actions:

I. Hospital Medical Staff Credentialing and Privileging

Waive enforcement of Health & Safety Code Sections 2282 and 2282.5, and California Code of Regulations, title 22, sections 70701 and 70703, for the duration of the declared emergency, as otherwise may be applied to require credentialing and privileging of licensed health care practitioners in a health care facility who are assisting in preparing for, responding to, mitigating the effects of, and recovering from COVID-19. Notwithstanding this waiver, a health care facility may continue to follow existing procedures and policies of the medical staff for granting disaster privileges.

Summary: Under California law, medical staffs have a statutory duty and right to credential and privilege all licensed physicians and other health care practitioners practicing at their hospital. See Bus. & Prof. Code §2282(b); 2282.5(a)(1)); 22 CCR §70703. Likewise, hospital licensure conditions require hospital boards to such credentialing and privileging of licensed health care practitioners. See 22 CCR §70701(a)(1)(E) and (a)(7)). Credentialing is the process of verifying qualifications to ensure current competence to grant privileges (i.e., verification of education, training, experience, and licensure to provide services). Privileging is the process of authorizing a specific scope of practice for patient care based on credentials and performance. Although Government Code 179.5 and the Governor’s declaration deems out-of-state licensed health care personnel to be “licensed” in this State for purposes of treating COVID-19,
there is yet no emergency action that suspends state law requirements for credentialing and privileging in hospitals. This Executive Order waives enforcement of any state law or regulation that requires credentialing and privileging of licensed health care personnel for purposes of treating COVID-19.

II. California Privacy Laws

Waive enforcement of Health & Safety Code Sections 1280.15, 1280.18, and Civil Code Sections 56.35, 56.26 of the California Medical Information Act (CMIA), Business & Professions Code 2290.5 (consent for use of telehealth services) and Civil Code Section 1798.82 (breach notification requirement). During the COVID-19 state of emergency, these laws would be waived and no enforcement action would be authorized (either by the State or through a private right of action) against covered health care providers subject to these laws for providing telehealth services in good faith through remote communication technologies that may not fully comply with the requirements of these privacy laws. This flexibility should apply to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. For example, a covered health care provider in the exercise of their professional judgement may request to examine a patient exhibiting COVID-19 symptoms, using a video chat application connecting the provider's or patient's phone or desktop computer to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a covered health care provider may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, specialty consultation or psychological evaluation, or other conditions.

Summary: HIPAA penalties for the good faith use of telehealth during the COVID-19 emergency have been suspended by the HHS Office for Civil Rights. However, the California Medical Information Act (CMIA) and other privacy laws remain in effect and continue to deter the broad use of remote communication technologies that might not appropriately protect patients "medical information." Health & Safety code section 1280.15 and the CMIA each obligate health care providers to prevent unlawful or unauthorized access to and disclosure of patients' medical information. Business and Professions Code section 2290.5 requires that prior to providing telehealth services, a healthcare provider must inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth. The consent must be documented. Until enforcement of Business and Professions code 2290.5 is waived, failure to obtain and document such consent during the good faith practice of telemedicine will continue to constitute unprofessional conduct in California. Data breaches in California require specific notification under Civil Code section 1798.82. Until enforcement is waived, healthcare providers are
required to immediately take steps for notification outlined by section 1798.82 upon
discovery of a breach or suspected breach of patient data. The CMIA provides a private
right of action for any patient whose medical information has been improperly used or
disclosed. Until Civil Code sections 56.35 and 56.36 are waived, patients in California will
continue to have a private right of action for the use or disclosure of a patient's medical
information even if such use or disclosure is made during a physician's good faith
provision of medical care.

III. Declare State of Emergency Immunity Laws to Encompass All COVID-19 Related
Activities by Licensed Health Care Providers (Government Code Section 8659;
Business & Professions Code Section 900(e).)

Declare that all acts and omissions to act by all licensed health care providers in relation
to or as a result of CoVid19 constitute services rendered during a state of emergency to
which California Government Code Section 8659 immunity applies.

Under California Government Code section 8659, any physician and surgeon licensed
in this state or any other state, hospital, pharmacist, respiratory care practitioner, nurse,
or dentist who renders services during any state of war emergency, a state of
emergency, or a local emergency at the express or implied request of any responsible
state or local official or agency shall have no liability for any injury sustained by any
person by reason of those services, regardless of how or under what circumstances or
by what cause those injuries are sustained; provided, however, that the immunity
herein granted shall not apply in the event of a willful act or omission.

Summary: In order to empower all licensed health care providers to respond to the
emergent call-to-action issued in the State of California and across the United States in
relation to the CoVid19 crisis, issue an executive order declaring that the Governor does
hereby expressly request that all licensed health care providers render services in
relation thereto, and that any licensed health care provider who performs or fails to
perform such services in relation to or as a result of the CoVid19 crisis shall not be
subject to civil, criminal, administrative, disciplinary, employment, credentialing,
professional discipline, contractual liability, or medical staff action, sanction, or penalty
or other liability and no cause of action shall exist or be brought against such licensed
health care provider in relation thereto.

IV. Physicians and Surgeons’ License Renewal

Waive enforcement of Business and Professions Code Sections 2423, 2424, and
2425 and California Code of Regulations, title 16, section 1352 and 1352.2 for the
duration of the declared emergency, as otherwise may be applied to require license
renewals for physicians who are assisting in preparing for, responding to, mitigating
the effects of, and recovering from COVID-19.

Summary: Under California law, the license to practice medicine in California must be
renewed every two years. It is illegal to practice medicine with an expired license. For
licenses issued after July 1, 2018, the license expires at midnight on the expiration date, which is the last day of the month in which it was issued. For licenses issued before July 1, 2018, the license expires at midnight on the expiration date, which is the last day of the physician's birth month.

A physician has two options for license renewal, by mail or online using the BreEZe Online Services. Physicians are eligible to renew your license online if the license is in active or inactive status, the license expires within the next 180 days, and the physician has completed the Continuing Medical Education requirements. Government Code 179.5 and the Governor’s declaration deems out-of-state licensed health care personnel to be “licensed” in this State for purposes of treating COVID-19, so waiving renewal requirements for physicians who are currently licensed in California is appropriate and would ensure continuity of care and address an administrative burden on physicians actively involved in the COVID-19 emergency.

This waives enforcement of state laws and regulations that require holders of a California medical license to comply with the deadline, fee and continuing medical education requirements for renewal for the duration of the COVID-19 emergency without revoking or placing the license in an inactive status. Physicians that do not comply with license renewal deadlines would not be subject to additional fees, penalties or loss of full active status for their medical license.

V. Reinstatement of Inactive Licenses

Waive enforcement of Business and Professions Code Section 2428 and California Code of Regulations, title 16, sections 1339.5 and 70703, for the duration of the declared emergency, as otherwise may be applied to require individuals who hold physician and surgeon certificates in inactive status who wish to convert their license to active status for purposes of assisting in preparing for, responding to, mitigating the effects of, and recovering from COVID-19.

Summary: Under California law, a physician who wishes to retain a license while not actively practicing medicine in the State of California may apply for an inactive or a retired license. Physicians on inactive or retired status:

- May not practice medicine in California.
- Do not need to comply with Continuing Medical Education (CME) requirements.

Inactivating a license does not change the expiration date, and the renewal fee is the same as the fee for an active license. To restore an inactive license to active status, the physician must complete the required CME for a single renewal period. At this time the completion of 50 hours of Category 1 CME meets this requirement.

Government Code 179.5 and the Governor’s declaration deems out-of-state licensed health care personnel to be “licensed” in this State for purposes of treating COVID-19, so waiving renewal and fee requirements for physicians who were formerly held an active license and
are on inactive status by choice in California is appropriate and would ensure continuity of care and address an administrative burden on physicians actively involved in the COVID-19 emergency.

This waives enforcement of any state law or regulation that requires physicians to pay the renewal fee and comply with continuing medical education requirements in order to reinstate their medical license from inactive or retired status to active status for the duration of the COVID-19 emergency.

VI. **California 1115 Medicaid Waiver: Emergency Amendment**

All states have been provided with an opportunity to seek an emergency 1115 waiver (attached and this is in addition to states also using a 1135 waiver [see attached notice from Centers for Medicare and Medicaid Services]). California should take advantage of this opportunity because (a) it does not require any budget neutrality calculation and (b) will allow the state to fund some important activities that it would otherwise not be able to. The state is already spending huge amounts of General Fund on hospitals, personal protective equipment (PPE), etc. This waiver would allow California to “Medicaidize” some of those expenditures, in essence letting the state dollar get doubled. We can seek to apportion some of the pandemic response to Medi-Cal under this waiver.

We are willing to help commit the resources to assist in drafting and staffing this request because we appreciate the rest of the Administration is appropriately focused on responding to the COVID crisis. We would work directly with DHCS and any others you deem necessary to support this waiver opportunity.

**California 1115 Medicaid Waiver: Emergency Amendment**

*Submit a one-year emergency request from March 1, 2020 through March 31, 2021.*

**Construct for Emergency Amendment**

- Seek an extension of California’s entire existing Medi-Cal 2020 waiver for a year (including PRIME, GPP and Whole Person Care) without needing to meet budget neutrality.
- Create a new Waiver program “Program” of an additional $1B in FFP for the period of March 1, 2020 through March 31, 2021.
- Program may be a mix of direct grants, payments through managed care and supplemental payments
- Program is intended to provide critical funding stability to California safety net providers and other significantly impacted providers that are essential for ensuring beneficiaries are receiving necessary services.
- Targeted providers for funding would include: hospitals, skilled nursing facilities, physicians, dentists, home health and behavioral health providers.
- Potential program components would include:
Retention payments for Medi-Cal providers (physicians, dentists, behavioral health providers). These would help prevent these critical safety net providers from closing their doors permanently due to the COVID emergency.

Hospital support for workforce, surge capacity, and financially-distressed hospitals

Home-visiting (or mobile health services) for vulnerable populations (elderly, disabled, homeless) and providers serving beneficiaries in the community

Provider wellness (support for front-line providers to help with stress/trauma associated with COVID response)

Increased wages/supplements to staff in skilled nursing facilities plus increased infection control practices

The construct of this waiver amendment is not particularly extensive, but we are committed to helping staff and resource this request. Please let us know if you need any additional information. We have also raised this initially with Director Gilbert at DHCS.

VII. Expanding Workforce to Expedite Administration of COVID-19 Testing

Suspension of limitation on who can administer COVID-19 tests – Under existing law, Medical Assistants (MAs) and Licensed Vocational Nurses (LVN) are not able to administer nasopharyngeal swabs, which are considered invasive procedures. The Centers for Disease Control and Prevention recommends collecting and testing an upper respiratory nasopharyngeal swab for initial COVID-19 diagnostic testing. Allowing MAs and LVNs, with appropriate training and documented competency, to administer the test during would free up other licensed practitioners to focus caring for patients that need advanced practice care. CMA remains committed to continuing a dialogue with you about additional ways to address workforce shortages in California during this crisis.

VIII. Relief from Health Plan and Insurer Administrative Burdens and Practices that Delay Timely Access to Care or Physician Workforce Availability

Timely filing extension – California law requires plans/insurers to allow at least 90 days for providers to submit claims (28 C.C.R 1300.71(b) and Insurance Code 10133.66(a)). This timeframe should be extended from 90 to 365 days to allow practices additional time to ensure claim submission.

Suspension of prior authorization requirements – Plans and insurers should suspend all prior authorization requirements for services and medication. Spending time on administrative tasks is not how physicians should be spending their time.
**Suspension of medical records requests** – Plans and insurers should suspend all medical records requests (i.e., risk adjustment audits, Special Investigations Unit audits, retrospective claim audits, etc.)

**Expedited credentialing** – Plans and insurers should create an expedited credentialing process, similar to what Medicare is doing, to allow non-contracted physicians or physicians who are already in the process of becoming credentialed to join the payors' networks.

**Suspend plan/insurer overpayment requests** – Currently, physicians have 30 working days in which to dispute payor refund requests. In an effort to remove the administrative burden on the practice, plans/insurers should suspend recoupment efforts for at least 180 days.

**IX. Additional Surge Capacity**

In addition to the recommendations above, the California Association of Surgery Centers (CASA) has outlined additional ways that ambulatory surgery centers (ASC) can support the work of community hospitals and ensure that ASC facilities, physicians and team members are best equipped to serve the community and take the load of hospitals at capacity. See attached memorandum from our colleagues at CASA.

The California Medical Association is committed to continuing its research to identify laws, regulations and administrative actions for consideration by your administration as we grapple with this public health emergency. We are willing to help commit the resources to drafting and researching the necessary code sections and regulations that need to be referenced in any Executive Order to effectuate action. In the coming days we will communicate additional recommendations.

Thank you for your consideration.

Respectfully Submitted,

Dustin Corcoran
CEO
California Medical Association

Attachments: 2
March 22, 2020

Dear State Medicaid Director:

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) (as amended (42 U.S.C. 1320b-5)). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6:00 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. We note that the emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the public health emergency, including any extensions.

In an effort to assist states with addressing the COVID-19 public health emergency, CMS has developed a new section 1115 demonstration opportunity available to states under title XIX (Medicaid) of the Act. Under this demonstration opportunity, effective retroactively to March 1, 2020, states may select from a variety of options to deliver the most effective care to their beneficiaries in light of the COVID-19 public health emergency. Section 1115(a) demonstration authorities approved pursuant to this opportunity are time limited, and will expire no later than 60 days after the end of the public health emergency.
The COVID-19 section 1115 demonstration opportunity can make available a number of authorities and flexibilities to assist states in enrolling and serving beneficiaries in Medicaid and to focus state operations on addressing the COVID-19 pandemic.

The COVID-19 demonstration opportunity can be used by states to extend home and community-based services (HCBS) flexibilities—available under the Disaster Relief Appendix K for 1915(c) to beneficiaries receiving 1915(c)-like services under section 1115 demonstrations—to beneficiaries receiving long-term supports and services (LTSS) under Medicaid state plan authorities described in section 1915(i) and 1915(k) of the Act. The demonstration opportunity can also be used by states to accept self-attestation of applicant resources, which will assist Medicaid agencies in making streamlined eligibility determinations for some vulnerable populations.

In light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President’s proclamation that the COVID-19 outbreak constitutes a national emergency consistent with section 1135 of the Social Security Act (Act), and the time-limited nature of demonstrations that would be approved under this opportunity, the Department will not require States to submit budget neutrality calculations for section 1115 demonstration projects designed to combat and respond to the spread of COVID-19. In general, CMS has determined that the costs to the Federal Government are likely to have otherwise been incurred and allowable. States will still be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the state’s response to the public health emergency in their evaluations of demonstrations approved under this opportunity.

Participating states will be required to complete a final report, which will consolidate all required monitoring and evaluation deliverables, one year after the end of the COVID-19 section 1115 demonstration authority. This report will capture data on demonstration implementation, lessons learned, and best practices for similar situations. CMS will provide additional guidance on the structure and content of the report.

Pursuant to 42 CFR 431.416(g), CMS has determined that the existence of unforeseen circumstances resulting from the COVID-19 public health emergency warrants an exception to the normal state and federal public notice procedures to expedite a decision on a proposed COVID-19 section 1115 demonstration. States applying for a COVID-19 section 1115 demonstration are not required to conduct a public notice and input process. CMS is also exercising its discretionary authority to expedite its normal review and approval processes to render decisions on state applications for COVID-19 section 1115 demonstrations. CMS will post all section 1115 demonstrations approved under this COVID-19 demonstration opportunity on the Medicaid.gov website.

Attached is a template that states may use to request a section 1115 demonstration project to combat the COVID-19 public health emergency. We will review state requests pursuant to this demonstration opportunity on a state-by-state basis.
State Medicaid Director

We recognize that this is a dynamic situation, and both states and CMS are updating their strategies to meet evolving needs. CMS may update this section 1115 demonstration opportunity to respond to Congressional or other action, as necessary. For more information about using section 1115(a) demonstration authority to support state efforts in combatting the COVID-19 public health emergency, please contact Judith Cash, Director, State Demonstrations Group, at 410-786-9686.

Sincerely,

Calder Lynch
Deputy Administrator and Director
Center for Medicaid and CHIP Services

Attachment
COVID-19 Section 1115(a) Demonstration Application Template

The State of ____________________, Department of ____________________ proposes emergency relief as an affected state, through the use of section 1115(a) demonstration authority as outlined in the Social Security Act (the Act), to address the multi-faceted effects of the novel coronavirus (COVID-19) on the state’s Medicaid program.

I. DEMONSTRATION GOAL AND OBJECTIVES

Effective retroactively to March 1, 2020, the State of ____________, seeks section 1115(a) demonstration authority to operate its Medicaid program without regard to the specific statutory or regulatory provisions (or related policy guidance) described below, in order to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

II. DEMONSTRATION PROJECT FEATURES

A. Eligible Individuals: The following populations will be eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

<table>
<thead>
<tr>
<th>Check to Apply</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current title XIX State plan beneficiaries</td>
</tr>
<tr>
<td></td>
<td>Current section 1115(a)(2) expenditure population(s) eligible for/enrolled in the following existing section 1115 demonstrations: [state to identify here]</td>
</tr>
</tbody>
</table>

B. Benefits: The state will provide the following benefits and services to individuals eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.
<table>
<thead>
<tr>
<th>Check to Apply</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current title XIX State plan benefits</td>
</tr>
<tr>
<td></td>
<td>Others as described here: [state to describe here]</td>
</tr>
</tbody>
</table>

C. Cost-sharing

<table>
<thead>
<tr>
<th>Check to Apply</th>
<th>Cost-Sharing Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals who will be enrolled in this demonstration that varies from the state’s current state plan.</td>
</tr>
<tr>
<td></td>
<td>Other as described here: [state to insert description]</td>
</tr>
</tbody>
</table>

D. Delivery System:

<table>
<thead>
<tr>
<th>Check to Apply</th>
<th>Delivery System Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the state’s current state plan.</td>
</tr>
<tr>
<td></td>
<td>Other as described here: [state to insert description]</td>
</tr>
</tbody>
</table>

III. EXPENDITURE AND ENROLLMENT PROJECTIONS

A. Enrollment and Enrollment Impact.
   i. State projects that approximately ____ individuals as described in section II will be eligible for the period of the demonstration. The overall impact of this
section 1115 demonstration is that these individuals, for the period of the
demonstration, will continue to receive HCBS or coverage through this
demonstration to address the COVID-19 public health emergency.

B. Expenditure Projection.
The state projects that the total aggregate expenditures under this section 1115
demonstration is $_______________.

In light of the unprecedented emergency circumstances associated with the COVID-19
pandemic and consistent with the President’s proclamation that the COVID-19 outbreak
constitutes a national emergency consistent with section 1135 of the Act, and the time-
limited nature of demonstrations that would be approved under this opportunity, the
Department will not require States to submit budget neutrality calculations for section
1115 demonstration projects designed to combat and respond to the spread of COVID-
19. In general, CMS has determined that the costs to the Federal Government are likely to
have otherwise been incurred and allowable. States will still be required to track
expenditures and should evaluate the connection between and cost effectiveness of those
expenditures and the state’s response to the public health emergency in their evaluations
of demonstrations approved under this opportunity.

IV. APPLICABLE TITLE XIX AUTHORITIES

The state is proposing to apply the flexibilities granted under this demonstration
opportunity to the populations identified in section II.A above.

<table>
<thead>
<tr>
<th>Check to Apply</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid state plan</td>
<td></td>
</tr>
<tr>
<td>Section 1915(c) of the Social Security Act (“HCBS waiver”). Provide applicable waiver numbers below:</td>
<td></td>
</tr>
<tr>
<td>Section 1115(a) of the Social Security Act (i.e., existing, approved state demonstration projects). Provide applicable demonstration name/population name below:</td>
<td></td>
</tr>
<tr>
<td>Other: [State to describe here]</td>
<td></td>
</tr>
</tbody>
</table>
V. WAIVERS AND EXPENDITURE AUTHORITIES

A non-exhaustive list of waiver and expenditure authorities available under this section 1115 demonstration opportunity has been provided below. States have the flexibility to request additional waivers and expenditure authorities as necessary to operate their programs to address COVID-19. If additional waivers or expenditure authorities are desired, please identify the authority needed where indicated below and include a justification for how the authority is needed to assist the state in meeting its goals and objectives for this demonstration. States may include attachments as necessary. Note: while we will endeavor to review all state requests for demonstrations to combat COVID-19 on an expedited timeframe, dispositions will be made on a state-by-state basis, and requests for waivers or expenditure authorities in addition to those identified on this template may delay our consideration of the state’s request.

A. Section 1115(a)(1) Waivers and Provisions Not Otherwise Applicable under 1115(a)(2)

The state is requesting the below waivers pursuant to section 1115(a)(1) of the Act, applicable for beneficiaries under the demonstration who derive their coverage from the relevant State plan. With respect to beneficiaries under the demonstration who derive their coverage from an expenditure authority under section 1115(a)(2) of the Act, the below requirements are identified as not applicable. Please check all that apply.

<table>
<thead>
<tr>
<th>Check to Waive</th>
<th>Provision(s) to be Waived</th>
<th>Description/Purpose of Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section 1902(a)(1)</td>
<td>To permit the state to target services on a geographic basis that is less than statewide.</td>
</tr>
<tr>
<td>[check box]</td>
<td>Section 1902(a)(8), (a)(10)(B), and/or (a)(17)</td>
<td>To permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.</td>
</tr>
<tr>
<td>[check box]</td>
<td>[insert here the statutory section of the Social Security Act]</td>
<td>[insert here the description/purpose of waiver]</td>
</tr>
<tr>
<td>[check box]</td>
<td>[insert here the statutory section of the Social Security Act]</td>
<td>[insert here the description/purpose of waiver]</td>
</tr>
<tr>
<td>[check box]</td>
<td>[insert here the statutory section of the Social Security Act]</td>
<td>[insert here the description/purpose of waiver]</td>
</tr>
</tbody>
</table>
### Check to Waive

<table>
<thead>
<tr>
<th>Provision(s) to be Waived</th>
<th>Description/Purpose of Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>[insert here the statutory section of the Social Security Act]</td>
<td>[insert here the description/purpose of waiver]</td>
</tr>
</tbody>
</table>

### B. Expenditure Authority

Pursuant to section 1115(a)(2) of the Act, the state is requesting that the expenditures listed below be regarded as expenditures under the state plan.

Note: Checking the appropriate box(es) will allow the state to claim federal financial participation for expenditures that otherwise would be ineligible for federal match.

<table>
<thead>
<tr>
<th>Check to Request Expenditure</th>
<th>Description/Purpose of Expenditure Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Allow for self-attestation or alternative verification of individuals’ eligibility (income/assets) and level of care to qualify for long-term care services and supports.</td>
</tr>
<tr>
<td></td>
<td>Long-term care services and supports for impacted individuals even if services are not timely updated in the plan of care, or are delivered in alternative settings.</td>
</tr>
<tr>
<td></td>
<td>Ability to pay higher rates for HCBS providers in order to maintain capacity.</td>
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<tr>
<td></td>
<td>The ability to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. For example, adult day sites have closed in many states due to isolation orders, and may go out of business and not be available to provide necessary services and supports post-pandemic</td>
</tr>
<tr>
<td></td>
<td>Allow states to modify eligibility criteria for long-term services and supports.</td>
</tr>
<tr>
<td></td>
<td>The ability to reduce or delay the need for states to conduct functional assessments to determine level of care for beneficiaries needing LTSS.</td>
</tr>
<tr>
<td>[check box]</td>
<td>Other: [insert here the description/purpose of the expenditure authority being requested]</td>
</tr>
<tr>
<td>[check box]</td>
<td>Other: [insert here the description/purpose of the expenditure authority being requested]</td>
</tr>
<tr>
<td>[check box]</td>
<td>Other: [insert here the description/purpose of the expenditure authority being requested]</td>
</tr>
</tbody>
</table>
VI. Public Notice
Pursuant to 42 CFR 431.416(g), the state is exempt from conducting a state public
notice and input process as set forth in 42 CFR 431.408 to expedite a decision on this
section 1115 demonstration that addresses the COVID-19 public health emergency.

VII. Evaluation Indicators and Additional Application Requirements

A. Evaluation Hypothesis. The demonstration will test whether and how the waivers and
expenditure authorities affected the state’s response to the public health emergency, and
how they affected coverage and expenditures.

B. Final Report. This report will consolidate demonstration monitoring and
evaluation requirements. No later than one year after the end of this demonstration
addressing the COVID-19 public health emergency, the state will be required to submit
a consolidated monitoring and evaluation report to CMS to describe the effectiveness of
this program in addressing the COVID-19 public health emergency. States will be
required to track expenditures, and should evaluate the connection between and cost
effectiveness of those expenditures and the state’s response to the public health
emergency in their evaluations of demonstrations approved under this opportunity.
Furthermore, states will be required to comply with reporting requirements set forth in
42 CFR 431.420 and 431.428, such as information on demonstration implementation,
progress made, lessons learned, and best practices for similar situations. States will be
required to track separately all expenditures associated with this demonstration,
including but not limited to administrative costs and program expenditures, in
accordance with instructions provided by CMS. CMS will provide additional guidance
on the evaluation design, as well as on the requirements, content, structure, and
submittal of the report.

VIII. STATE CONTACT AND SIGNATURE

State Medicaid Director Name: ________________________________
Telephone Number: ________________________________
E-mail Address: ________________________________

State Lead Contact for Demonstration Application: ________________________________
Telephone Number: ________________________________
E-mail Address: ________________________________

Authorizing Official (Typed): ________________________________
Authorizing Official (Signature): ________________________________
Date: ________________________________
PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1115 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Judith Cash at 410-786-9686.
Draft 3.23.2020 / 9:00 a.m.

Concerns that hospitals will be overwhelmed have not been tempered. There is growing alarm among providers as to how federal and state officials will maintain our nation’s and state’s health care infrastructure so that hospitals are not the only care setting left in operation as the pandemic takes its toll, and to ensure that patients have access to postponed care once it has subsided. ASCs can and must play a role in ensuring that communities’ health needs are met both during and following the cessation of the pandemic.

In order to best support our community hospitals that are at the center of care in this time of crisis, a list of ways that our ASC facilities, physicians, and team members are best equipped to serve the community and take the load off of hospitals has been compiled.

1. In response to COVID-19, ASCs have already implemented a stringent protocol around urgent elective vs. elective procedures. Many CA ASCs have closed or are limiting operations to 1 to 2 days a week to respond to those urgent patients. A good number are also working closely with their hospitals and health systems to provide relief from their surge of patients and hospitals are migrating their appropriate urgent elective procedures to the ASC environment.

2. Our colleagues in the Pacific Northwest have communicated the daily huddles led by local community Incident Command Centers are having a positive impact. As California implements this communication, ASC leaders need to be included. These huddles have led to proactive support of the system from workforce capacity, supply inventory & patient bed availability.

3. CASA in collaboration with the California Medical Association, distributed a survey to California ASCs to compile information on ASC ventilator inventory, personal protective equipment (PPE) inventory, number of staff, number of operating rooms (ORs), and preoperative and post-operative bays.

4. Below are options ASCs can provide that will need waivers of current sections of CA law and restrictions in order to fully implement and provide the greatest resources and availability to the statewide response to COVID-19.

Option 1: ASCs can take outpatient urgent elective procedures now as we are best positioned to do so based on our existing capabilities.

<table>
<thead>
<tr>
<th>Proposed Service</th>
<th>Requirements</th>
<th>Regulatory Engagement Required</th>
</tr>
</thead>
</table>
| Take on urgent surgeries for the community at an ASC | • Coordination with hospital system of urgent elective surgeries.   
• Common community adoption of urgent surgeries  
• Facility medical director involved in determining medical necessity and patient risk  
• Temporary privileges; accelerated credentialing  
• Consider increasing ASA Class to include “4s”  
• Consider expanded hours of operation, including weekends | • CMS defines ASC max ASA Class as 3  
• CMS/AO notification  
• Eliminate length of stay restrictions- waiver to H&S 1204.1, 1248.1 (a)(g) |
### Option 2: ASCs can transition to accommodate complex surgical cases.

<table>
<thead>
<tr>
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<th>Requirements</th>
<th>Regulatory Engagement Required</th>
</tr>
</thead>
</table>
| Migrate overflow surgical case volume; inpatient and outpatient | - Temporary privileges  
- Consider expanded hours of operation including weekends  
- Fits within the center's current specialty offering  
- Expand our CPT list based on current specialties offered at the center  
- Hospital to potentially assist in providing necessary equipment, staff and supplies | - Expanded list of reimbursed codes - In addition to CMS need waiver requiring health plans to accept payment of procedures at an ASC  
- Eliminate length of stay restrictions - waiver to H&S 1204.1, 1248.1 (a)(g) |

### Option 3: ASCs can expand our services to meet the different needs you may have based on the assets we have in place across the country.

<table>
<thead>
<tr>
<th>Proposed Service</th>
<th>Requirements</th>
<th>Regulatory Engagement Required</th>
</tr>
</thead>
</table>
| Triage Center – diversion from Emergency Room       | - Scope of service revision  
- Need on site MD or mid-level staffing  
- Consider expanded hours of operation including weekends  
- Rapid patient assessment and deployment to appropriate level of care  
- Isolation plan for suspected COVID cases | - Licensing – waiver to H&S 1204.1 plus 1248  
- Ability to transfer from hospital to ASC  
- Ability to provide non-surgical services in ASC |
| Serve as Infusion Center                            | - Scope of service revision—determine what type of infusions (fluids, chemo, immunotherapy, blood, globulins, IV hydration, etc.)  
- Pharmaceutical procurement  
- Determine blood source  
- Teammate training or identify dedicated team  
- Cancer treatment (w disposal system)  
- Additional infusion pumps | - Licensing  
- Payment methodology if not on ASC list  
- Ability to provide non-surgical services in ASC |
| Provide inpatient overnight beds                    | - Focus on patients that just need 1-2-day length of stay before discharge home or rehab center  
- Acute care non-ICU/non-isolation | - Licensing  
- Payment methodology  
- Eliminate length of stay restriction |
| Birthing Suite                                      | - Appropriate equipment  
- Hospital assist in providing necessary equipment, staff and supplies, including food service  
- Staffing—highly specialized nursing skill set  
- Explicit and early discussion and alignment of admission criteria  
- Nursery arrangement for high risk infants  
- Could do rooming in for healthy babies  
- OB medical staff call list | - Licensing  
- Ability to provide non-surgical services in ASC  
- Payment methodology  
- Eliminate time limit on length of stay |
Serve as an Urgent Care center – Non-COVID-19 patients

- Scope of service revision
- Need on site MD or mid-level staffing
- Determine hours of service
- Colds/flu, bumps/bruises, stiches, burns, stings, allergic reactions, vaccines, minor infections, Fractures and sprains, lacerations, x-rays, dehydration

- Licensing
- Ability to provide non-surgical services in ASC
- Payment methodology

Option 4: ASCs can further expand our services to meet the community’s needs. Once these are employed, it would be difficult to go back to providing the services in Options 1-3.

<table>
<thead>
<tr>
<th>Proposed Service</th>
<th>Requirements</th>
<th>Regulatory Engagement Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 Testing and Triage Center</td>
<td>• Scope of service revision</td>
<td>• Licensing</td>
</tr>
<tr>
<td></td>
<td>• Need on site MD or mid-level staffing</td>
<td>• Ability to provide non-surgical services in ASC</td>
</tr>
<tr>
<td></td>
<td>• Determine how to quarantine and isolate high risk</td>
<td>• Payment methodology</td>
</tr>
<tr>
<td></td>
<td>• Determine hours of service</td>
<td></td>
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<td></td>
<td>• Need test kits—which I understand are limited county by county</td>
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<td></td>
<td>• Dependent upon current utilization of the ASC</td>
<td></td>
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<tr>
<td></td>
<td>• Hospital would need to provide necessary supplies</td>
<td></td>
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<tr>
<td>ICU setting</td>
<td>• Appropriate equipment</td>
<td>• Licensing</td>
</tr>
<tr>
<td></td>
<td>• Dependent on existing building’s design and isolation requirements; air flow etc.</td>
<td>• Eliminate time limit on length of stay</td>
</tr>
<tr>
<td></td>
<td>• Trained Staff</td>
<td>• Ability to provide non-surgical services in ASC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Payment methodology</td>
</tr>
</tbody>
</table>

HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1797.8]
( Division 2 enacted by Stats. 1939, Ch. 60. )

H&S 1204.1

(1) A “surgical clinic” means a clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours. A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.

CHAPTER 1.3. Outpatient Settings [1248 - 1248.85]
( Chapter 1.3 added by Stats. 1994, Ch. 1276, Sec. 2. )

1248.

For purposes of this chapter, the following definitions shall apply:
(a) “Division” means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.
(b) (1) “Outpatient setting” means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient’s life-preserving protective reflexes.

(2) “Outpatient setting” also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55.

(3) “Outpatient setting” does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient’s life-preserving protective reflexes.

(c) “Accreditation agency” means a public or private organization that is approved to issue certificates of accreditation to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

(Amended by Stats. 2011, Ch. 645, Sec. 2. (SB 100) Effective January 1, 2012.)

1248.1

No association, corporation, firm, partnership, or person shall operate, manage, conduct, or maintain an outpatient setting in this state, unless the setting is one of the following:

(a) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

(b) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1601 of Title 25 of the United States Code, and located on land recognized as tribal land by the federal government.

(c) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies.

(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

(e) Any health facility licensed as a general acute care hospital under Chapter 2 (commencing with Section 1250).

(f) Any outpatient setting to the extent that it is used by a dentist or physician and surgeon in compliance with Article 2.7 (commencing with Section 1646) or Article 2.8 (commencing with Section 1647) of Chapter 4 of Division 2 of the Business and Professions Code.

(g) An outpatient setting accredited by an accreditation agency approved by the division pursuant to this chapter.

(h) A setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e), and in which the procedures performed are staffed by the medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process of the facility but which setting is not a part of a facility described in subdivision (a), (d), or (e).

Nothing in this section shall relieve an association, corporation, firm, partnership, or person from complying with all other provisions of law that are otherwise applicable.

(Added by Stats. 1994, Ch. 1276, Sec. 2. Effective January 1, 1995.)

1248.15

(a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings’ operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

P.O. Box 292698 ■ Sacramento, CA 95829 ■ Phone 530.790.7990 ■ Fax 530.790.7644 ■ www.casurgery.org
(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility’s medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(iii) Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(D) The outpatient setting shall submit for approval by an accreditation agency at the time of accreditation a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations. The plan shall include, at a minimum, that if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:

(i) Notify the individual designated by the patient to be notified in case of an emergency.

(ii) Ensure that the mode of transfer is consistent with the patient’s medical condition.

(iii) Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

(iv) Continue to provide appropriate care to the patient until the transfer is effectuated.

(E) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility’s peer review outcome shall be reported, as appropriate, to the accrediting body or in accordance with existing law.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) (i) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(ii) Each licensee who performs procedures in an outpatient setting that requires the outpatient setting to be accredited shall be, at least every two years, peer reviewed, which shall be a process in which the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of a licensee is reviewed to make recommendations for quality improvement and education, if necessary, including when the outpatient setting has only one licensee. The peer review shall be performed by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The findings of the peer review shall be reported to the governing body, which shall determine if the licensee continues to meet the requirements described in clause (i). The process that resulted in the findings of the peer review shall be reviewed by the accrediting agency at the next survey to determine if the outpatient setting meets applicable accreditation standards pursuant to this section.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.
(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.
(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.
(10) Outpatient settings shall have a written discharge criteria.
(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.
(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.
(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.
(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.
(f) The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting as specified in Section 1248.
(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, “conducting a reasonable investigation” means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision. 
(Amended by Stats. 2015, Ch. 287, Sec. 3. (SB 396) Effective January 1, 2016.)