Washington State Hospital Association

August 5, 2026

Centers for Medicare & Medicaid Services
Office of the Secretary
400 7th Street SW, Room 1000
Washington, DC 20024

Re: Washington State Hospitals Urgent Request for Section 1135 Federal Flexibilities to Support Wildfire Response

VIA E-MAIL

Dear Secretary Kennedy:

Washington state's hospitals in the area of the declared federal emergency are and will continue to be on the frontlines of wildfire response. The fires are not yet contained and impacts are expected to continue for weeks to come. They are experiencing increased demand for services from community members impacted by smoke, especially those with underlying lung and cardiac conditions and caring for medical needs of firefighters. Staffing challenges are significant because many have lost their homes and are displaced by evacuation orders. One local hospital had to be evacuated resulting in transfer of patients into facilities that are open. While they do not have acute medical needs, residents of local adult family homes have been dropped off at hospitals leading to increased census and demands on staff, space, and supplies. Fires are making transportation in the area challenging, which may soon impact supply availability.

Because of these factors, hospitals in the impacted areas in Washington State (Chelan, Ferry, Okanogan, Spokane, Stevens and Yakima counties) are respectfully requesting HHS Secretary Kennedy grant the State of Washington's request to declare a public health emergency for the impacted areas of the state. We also request your approval of the following waivers and modifications under Section 1135 of the Social Security Act for hospitals in these areas:

1. **Medicare Conditions of Participation (CoPs)**. The hospitals are requesting blanket waivers to the following CoPs:
   - **Discharge Planning.** 42 C.F.R. §482.43(a)(8), 485.642(a)(8) Hospitals can discharge patients who no longer need acute care based solely upon which post-acute providers that can accept them without sharing the data requested by the regulators. Allowing for discharges in an efficient manner will free beds for acutely ill patients.
   - **Physical Environment**. 42 C.F.R. §482.41; A-0700 et seq; Non-hospital buildings/space can be used for patient care, provided sufficient safety and comfort is provided for patients and staff - allow hospitals to treat medical/surgical patients in non-PPS hospitals. This is another measure that will free up inpatient care beds for the most acute patients while providing beds for those still in need of care.

- **Verbal Orders** §482.24, A-0407, A-0454, A-0457 Verbal orders may be used more than 'infrequently' (read-back verification is done) and authentication may occur later than 48 hours. This will allow for more efficient treatment of patients in a surge situation.
- **Medical Staff.** 42 C.F.R. §482.22(a); A-0341 So that physicians whose privileges will expire and new physicians can practice before full medical staff/governing body review and approval. This will keep clinicians on the front line and allow hospitals and health systems to prioritize patient care needs during the emergency.
  Medical Records Timing. 42 C.F.R. §482.24; A-0469 Medical records can be fully completed later than 30 days following discharge. This flexibility will allow clinicians to focus on the care needs at hand and deal with paperwork later.

2. **Home Health**. 42 C.F.R. § 484.55(a); Home health agencies can perform certifications, initial assessments and determine patients' homebound status remotely or by record review. This will allow patients to be cared for in the best environment while reducing impact on acute care and long-term care facilities. This will allow for maximizing coverage by already scarce physicians and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.

3. **Delivery of Services in Alternate Clinic Locations.** Waiver/flexibility to allow hospital-based clinic providers, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers to bill for their Prospective Payment System (PPS) rate, or other permissible reimbursement, when providing services from alternative physical settings, such as a mobile clinic or temporary location.

4. **Flexibility for Teaching Hospitals.** Allow flexibility in how the teaching physician is present with the patient and resident. Medicare generally requires that the physician be physically present in the room/area to bill as the teaching physician. Hospitals are experiencing severe staff shortages with staff who are directly impacted by their own requirement to evacuate their homes.

5. **Timely Filing Requirements for Billing.** 42 CFR 424.44 Waiver of timely filing requirements that will allow providers getting correct coding and other structural pieces built into their systems and even payer ability to adjudicate.

6. **Alternate care sites.** Allow non-licensed facilities to take patients who do not need acute care but are in the hospital for other reasons: single bed certification for involuntary mental health holds held in non-psychiatric units, awaiting a guardian, awaiting Medicaid approval so they can be discharged, etc. Allow alternative care sites (like tents) and clarify that the provider-based rules, life safety code and CoPs do not apply. Allow ambulatory surgical centers, critical access hospitals, and other licensed independent facilities to serve as "overflow" for patients transferred from acute care hospitals, with waivers of CoP or certification requirements for those entities to allow them to accept such patients, and provide adequate federal health care program reimbursement for those facilities. Reimburse providers for a service provided in an unlicensed location.

7. **Deadlines.** Suspend billing timeframes and require Medicare Advantage and Part D plans to do the same. Suspend cost report settlement timeframes, including repayment due dates. Suspend HIPAA breach notification timeframes. We request that all requirements be

waived permanently or suspended until at least 180 days after termination of the emergency declaration.

8. **Audits and reporting.** Pause all audit activity and require Medicare Advantage and Part D plans to do the same. Waive various reporting deadlines (including quality reporting) permanently or until 180 days after termination of the emergency declaration.

9. **Medicare observation requirements.** Suspend the requirement to provide the MOON and the 23-hour rule. Waive patient signature requirements for MOON. Waive patient cost-sharing for observation services. Waive any limitations under Medicare or Medicaid for the number of reimbursable hours of observation. Permit for billing of observation services rendered via remote monitoring methods.

10. **Hospital reimbursement.** Clarify that hospitals may bill special care unit codes (ICU, CCU, NICU, ED) if the patient meets level-of-care criteria, even if the patient is cared for in what is usually considered a PACU, OR suite, or med/surg bed or space. Similarly, clarify that a hospital may bill at acute or special unit levels for what are usually considered DP NF beds if the patient meets acute level criteria. Clarify that hospitals may bill for ED/provider-based reimbursement for newly established services, such as drive-through, tent, and off-site screening and testing locations. Reimburse hospitals for "administrative days" in addition to the DRG payment, once a Medicare beneficiary is ready for discharge but there's no place for them to go.

11. **Freestanding rehabilitation and psychiatric hospital services.** Allow distinct part units (SNF, rehab and psych) to provide acute inpatient care if the patient meets level-of-care criteria. We request the same for freestanding SNFs, RFS, rehab and psych hospitals, and ambulatory care centers.

12. **72-hour Window Rule for IPPS Hospitals/1-Day Rule for CAHs.** Waive this rule related to billing outpatient services pre-dating an inpatient admission on the inpatient claim so that beneficiaries may be seen in a hospital, or affiliated clinic, or via telehealth and reimbursement will be made to that provider separately for the outpatient services by CMS, and reimburse hospitals for the full DRG for a subsequent hospitalization.

13. **Transfer Reductions**. Remove federal healthcare program transfer-related reductions to payment for transfers that are driven by the emergency and need to free up acute care beds for the highest acuity patients.

14. **Swing beds.** Allow critical access hospitals that do not usually provide swing beds to accept and be paid for swing bed patients from other facilities to maximize the region's acute care capacity, whether those beds are used for inpatient or SNF-level care, to maximize the acute care capacity available statewide and the availability of those beds in hospitals with specialized capabilities for the most acutely ill patients.

15. **Medicare Advantage and Part D plans.** Allow out-of-network providers to be reimbursed for medically necessary acute care and post-acute care without prior authorization. Require these plans to suspend utilization management activities. Require these plans to consider presenting symptoms as a basis for coverage, not final diagnosis.

16. **Staffing.** Allow hospitals to disregard provisions in their medical staff by laws relating to expiration of and granting of privileges – 42 C.F.R. section 482.22. Authorize military health care personnel to work in civilian settings, without requiring privileging.

17. **Emergency Medical Treatment and Active Labor Act (EMTALA).** We request the ability to redirect or reallocate individuals who come to the emergency department without an obvious emergency medical condition to non-hospital controlled locations. We request the ability to designate qualified medical providers to perform EMTALA screenings without the usual administrative/board action or incorporation into the medical staff bylaws or rules and regulations. We request that CMS expand the definition of appropriate transfer to allow for the transfer of patients to a facility offering a lower level of care without the patient's prior consent, so long as the accepting facility has the capacity and capability to treat the patient. Similarly, we request that hospitals be allowed to deny a transfer unless the accepting facility offers a level of care needed by the patient that cannot be provided by the transferring facility. Waive sanctions for transfer of an unstabilized patient as needed by the public health emergency.

18. **HIPAA.**
    - In addition to suspending the HIPAA breach notification timeframes until at least 180 days after termination of the emergency as requested above, we request that CMS clarify that the current HIPAA waiver lasts for the duration of the emergency, and not just for the first 72 hours after the hospital activates its emergency response plan.
    - Waive sanctions and penalties arising from noncompliance with the following provisions of the HIPAA privacy regulations: (a) the requirements to obtain a patient's agreement to speak with family members or friends or to honor a patient's request to opt out of the facility directory (as set forth in 45 C.F.R. § 164.510); (b) the requirement to distribute a notice of privacy practices (as set forth in 45 C.F.R. § 164.520); and (c) the patient's right to request privacy restrictions or confidential communications (as set forth in 45 C.F.R. § 164.522). This allows flexibility for hospitals to provide information in a place and manner appropriate for the circumstances during the emergency.

19. **Behavioral health.** Allow patients to remain eligible for partial hospitalization and intensive outpatient programs despite potential disruptions to their care. Allow therapy hours to be provided via telehealth or a blend of in-person and telehealth care for both reimbursement purposes and compliance with program requirements. Allow hospitals who do not accept single bed certifications to hold involuntarily detained patients to hold the patient until a certified bed can be located. Waive the time, distance and attendance standards for reimbursement purposes.

20. **Texting.** Allow texting of patient orders. See S&C 18-10-ALL.

21. **Interpreter and translation services.** Clarify that providers may rely on family members or friends if a professional interpreter or translator (even remote) is not reasonably available.

22. **Administrative requirements.** Allow hospital staff to focus on the most urgent patient care needs by suspending the requirement for hospitals to provide each patient an individual notice of rights, including requirements under the Patient Self-Determination Act, and to respond to patient grievances.

23. **<u>Efficient patient discharge</u>.** Clarify that a patient who no longer needs acute care may be discharged to any appropriate post-acute care provider that will accept the patient regardless of network status of the receiving provider and regardless of patient choice. Suspend the requirement to provide patients the Important Message from Medicare, which allows them to appeal discharge, and effectively delay it for a day or two.

We appreciate your consideration of this request. Please send any follow up communications to tayab@wsha.org and zosias@wsha.org.

Taya Briley, Executive Vice President and General Counsel