Federal Waivers Issued During the COVID-19 Public Health Emergency

January 27, 2020 – October 17, 2022

IROQUOIS Healthcare Association

Nature of Waiver	*Scope*	*Issued by*
Advance Directives	CMS is waiving the requirements at section 1902(a)(58) and 1902(w)(1)(A) for Medicaid, 1852(i) (for Medicare Advantage); and 1866(f) and 42 CFR 489.102 for Medicare, which require hospitals and CAHs to provide information about its advance directive policies to patients. This would not apply to the requirements at §482.13(a) for hospitals and at §485.608(a) for CAHs to receive information about the presence of a policy regarding the facility's recognition of advance directives.	CMS
Blanket Waivers of Sanctions Under the Physician Self-Referral Law	The blanket waivers may be used now without notifying CMS. Individual waivers of sanctions under section 1877(g) of the Social Security Act may be granted upon request.	CMS
Discharge Planning for Hospitals	CMS is waiving all the requirements and subparts of 42 CFR §482.43(c), which are related to post-acute care services, so as to expedite the safe discharge and movement of patients among care settings, and to be responsive to fluid situations in various areas of the country. CMS is waiving the requirement that for those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the hospital must: §482.43(c)(1) include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient; §482.43(c)(2): must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services ....and that; §482.43(c)(3): The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare	CMS
Discharge Planning for Hospitals	CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care as described in 42 CFR §482.43(a)(l)-(7) and (b).	CMS
Discharge Planning for Hospitals and CAHS	CMS is waiving the requirement to provide detailed information regarding discharge planning as outlined in 42 CFR §482.43(a)(8), §482.61(e), and 485.642(a)(8), described below:The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to home health agency (HHA), SNF, IRF, or LTCH data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.	CMS
Durable Medical Equipment (DME)	Waives requirements for replacing lost or damaged DME, including face-to-face requirement, physician's order, and medical necessity documentation.	CMS
Fair Hearings	Extending the time periods for managed care plans to resolve appeals	CMS - NYS
Food and Dietetic Services	42 CFR §482.28{b) (3), which requires providers to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel. Such manuals would not need to be maintained at surge	CMS

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	capacity sites. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	
Home Health	Relieves timeframes for Open Access Same-Time Information System (OASIS) transmission and allows Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of requests for anticipated payment during emergency.	CMS
Laboratory - Sterile Compounding	CMS is waiving requirements (also outlined in USP797) at 42 CFR §482.25(b)(1) and §485.635(a)(3) to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only.	CMS
Licensure – CAH	CMS is deferring to staff licensure, certification, or registration to state law by waiving 42 CFR §485.608{d) regarding the requirement that staff of the CAH be licensed, certified, or registered in accordance with applicable Federal, state, and local laws and regulations. This waiver will provide maximum flexibility for CAHs to use all available clinicians. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS
Long-Term Acute Hospitals	Allows a LTCH to exclude patient stays where an LTCH admits or discharges patients to meet the demands of the emergency from the 25-day average LOS requirement, which allows these facilities to be paid as LTCHs.	CMS
LTCH LOS	Hospitals may exclude patient stays from the 25-day average LOS requirement for patients admitted and discharged to meet emergency demands.	CMS
Medical Records	CMS is waiving requirements 42 CFR §482.24(c)(4)(viii) and §485.638(a)(4)(iii), which are related to medical records, to allow flexibility in completion of medical records within 30 days following discharge and for CAHs that all medical records must be promptly completed.	CMS
Medical Staff	CMS is waiving requirements 42 CFR §482.22(a) and §485.627(a)to allow physicians whose privileges will expire to continue practicing at the hospital or CAH and for new physicians to be able to practice in the hospital or CAH before full medical staff/governing body review and approval.	CMS
Medicare Appeals	Extends the time to file appeals and waives other timelines.	CMS
Medicare Appeals	Extends time to file an appeal; Waives timeliness for requests for additional information to adjudicate the appeal; Processes the appeal even with incomplete Appointment of Representation forms but communicates only to the beneficiary; Processes requests for appeal that don’t meet the required elements using information that is available; Uses all flexibilities available in the appeal process as if good cause requirements are satisfied	CMS
Medicare Appeals	CMS is allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractors (QICs) in the FFS program pursuant to 42 CFR §405.942 and 42 CFR §405.962 (including for MA and Part D plans), and MA and Part D Independent Review Entities (IREs) under 42 CFR §422.562, 42 CFR §423.562, 42 CFR §422 .582, and 42 CFR §423.582, extensions to file an appeal. CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 and the MA and Part D IREs to waive requests for timeliness requirements for additional information to adjudicate appeals.	CMS
Medicare Enrollment	Expedites enrollment services.	CMS

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Medicare Graduate Medical Education (GME) Affiliation Agreement	CMS waived the July 1 submission deadline under 42 CFR 413.79(f)(1) for new Medicare GME affiliation agreements and the June 30 deadline under the May 12, 1998 Health Care Financing Administration Final Rule (63 FR 26318, 26339, 26341) for amendments of existing Medicare GME affiliation agreements.	CMS
Nursing Services	42 CFR §482 .23(b)(4), which requires the nursing staff to develop and keep current a nursing care plan for each patient, and §482.23(b)(7), which requires the hospital to have policies and procedures in place establishing which outpatient departments are not required to have a registered nurse present	CMS
Patient Rights	CMS is waiving requirements under section 42 C.F.R. §482.13 only for hospitals that are considered to be impacted by a widespread outbreak of COVID-19. Hospitals that are located in a state that has widespread confirmed cases would not be required to meet the following requirements: 42 C.F.R. §482.13(d)(2) with respect to timeframes in providing a copy of a medical record; 42 C.F.R. §482.13(h) related to Patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID-19 isolation and quarantine processeso 42 C.F.R. §482.13(e)(C)(1)(ii) regarding seclusion	CMS
Physician Services	The requirements under 42 CFR §482.12(c)(l)-(2) and§482.12(c)(4), which require that Medicare patients be under the care of a physician. This waiver may be implemented so long as it is not inconsistent with a state's emergency preparedness or pandemic plan. This allows hospitals to use other practitioners to the fullest extent possible.	CMS
Practitioner locations	CMS is waiving the requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state provided that they: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state which relates to his or her Medicare enrollment; 3) are furnishing services - whether in person or via telehealth - in a state in which the emergency is occurring to contribute to relief efforts in his or her professional capacity; and, 4) are not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.	CMS
Provider Enrollment	Establishes a toll-free hotline for non-certified Part B suppliers, physicians, and nonphysician practitioners to enroll and receive temporary Medicare billing privileges. Waives the following screening requirements: Application Fee - 42 C.F.R 424.514; Criminal background checks associated with FCBC - 42 C.F.R 424.518; Site visits - 42 C.F.R 424.517; Postpones all revalidation actions; Allows licensed providers to render services outside of their state of enrollment; Expedites any pending or new applications from providers	CMS
Provider Enrollment (Non-waiver CMS Action)	CMS has a toll-free hotline for physicians and non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. CMS is waiving the following screening requirements: Application Fee (to the extent applicable); Criminal background checks associated with fingerprint-based criminal background checks (FCBC) (to the extent applicable) - 42 CFR §424.518; Site visits (to the extent applicable) - 42 CFR §424.517; Postpone all revalidation actions; Allow licensed providers to render services outside of their state of enrollment; Expedite any pending or new applications from providers; Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location; Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients	CMS
Provider Screening and Enrollment	Waives application fee to enroll providers on a temporary basis	CMS - NYS

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Quality Assessment and Performance Improvement Program	42 CFR §482.21(a)-(d) and (f), and §485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated Quality Assurance & Performance Improvement programs (for hospitals that are part of a hospital system).	CMS
Reporting - IPPS Wage Index Occupational Mix Survey Submission	CMS granted an extension for hospitals nationwide affected by COVID-19 until August 3, 2020 and has further extended this deadline to September 3, 2020. Hospitals must submit their occupational mix surveys along with complete supporting documentation to their MACs by no later than September 3, 2020. Hospitals may then submit revisions to their occupational mix surveys to their MACs, if needed, by no later than September 10, 2020.	CMS
Reporting - IPPS Wage Index Occupational Mix Survey Submission	CMS is extending the submission date for the 2019 Occupational Mix Surveys, Hospital Reporting Form CMS-10079, for the wage index beginning fiscal year 2022, which would otherwise be due by July 1, 2020, to the MACs on the Excel hospital reporting form to August 3, 2020. If hospitals encounter difficulty meeting this extended deadline date, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.	CMS
Reporting - Medicare Geographic Classification Review Board	Per requirements at section 1886(d)(10)(C)(ii) of the Social Security Act (the Act) and 42 CFR 412.256(a)(2), September 1, 2020 is the deadline to submit an application to the Medicare Geographic Classification Review Board (MGCRB) for FY 2022 reclassifications. These provisions require applications to be filed through OHCDMS	CMS
Reporting – Quality Programs	Quality Reporting data submission and performance calculations for following programs: Ambulatory Surgical Centers; CrownWeb National ESRD Patient Registry & Quality Measure; ESRD Quality Incentive; Hospital Outpatient; Hospital Readmissions Reduction; Hospital Value-Based Purchasing; Hospital-Acquired Condition Reduction; Inpatient Psychiatric Facility; PPS-Exempt Cancer Hospital; Promoting Interoperability Program for Eligible Hospitals & CAHs;	
Reporting Requirements	CMS is waiving the requirements of 42 CFR. §482.13(g) (1)(i)-(ii), which require hospitals to report patients in an intensive care unit whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs may be reported later than close of business next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits.	CMS
Respiratory Care Services	42 CFR §482.57{b)(1), which requires hospitals to designate in writing the personnel qualified to perform specific respiratory care procedures and the amount of supervision required for personnel to carry out specific procedures. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan	CMS
Scope of Practice - Anesthesia Services	CRNA supervision will be at the discretion of the hospital and state law. This waiver applies to hospitals, CAHs, and ASCs. These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS
Scope of Practice - CAH	The minimum personnel qualifications for clinical nurse specialists at paragraph 42 CFR §485.604{a)(2), nurse practitioners at paragraph §485.604{b)(1)-{3), and physician assistants at paragraph §485.604{c)(1)-{3). Removing these Federal personnel requirements will allow CAHs to employ individuals in these roles who meet state licensure requirements and provide maximum staffing flexibility. These flexibilities should be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS

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Skilled Nursing Facility (SNF) Three-Day Admission	Waives the requirement for a three-day admission prior to transfer of patient to SNF.	CMS
Surge Capacity - Acute Care in Excluded Distinct Part Units	Allows hospitals to place acute care patients in excluded distinct part units if such beds are appropriate for acute care. Inpatient prospective payment system (IPPS) hospitals should bill accordingly and document in the medical record that the patient is there for capacity issues relating to the emergency.	CMS
Surge Capacity - CAH LOS	The requirements that CAHs limit the number of beds to 25, and that the LOS be limited to 96 hours under the Medicare conditions of participation for number of beds and LOS at 42 CFR §485.620	CMS
Surge Capacity – CAH LOS	Waives the 25-bed limit and 90-hour average length of stay (LOS).	CMS
Surge Capacity - Care for Patients in Extended Neoplastic Disease Care Hospitals	CMS is allowing extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients to meet the demands of the emergency from the greater than 20-day average LOS requirement, which allows these facilities to be excluded from the hospital IPPS and paid an adjusted payment for Medicare inpatient operating and capital-related costs under the reasonable cost-based reimbursement rules as authorized under Section 1886(d)(l)(B)(vi) of the Act and §42 CFR 412.22(i).	CMS
Surge Capacity - Emergency Preparedness Policies and Procedures	42 CFR §482.lS(b) and §485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and §482.lS(c)(l)-(S) and §485.625(c)(l)-(S), which requires that the emergency preparedness communication plans for hospitals and CAHs to contain specified elements with respect to the surge site. The requirement under the communication plan requires hospitals and CAHs to have specific contact information for staff, entities providing services under arrangement, patients' physicians, other hospitals and CAHs, and volunteers. This would not be an expectation for the surge site. This waiver applies to both hospitals and CAHs.	CMS
Surge Capacity - Long-term Care Services	CMS waived the requirements at 42 CFR 482.58, "Special Requirements for hospital providers of long-term care services ("swing-beds")" subsections (a)(1)-(4) "Eligibility", to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. In order to qualify hospitals must meet the criteria set forth by CMS. Hospitals must also call the CMS Medicare Administrative Contractor to add swing beds and provide the attestation required by CMS. The hospital shall not bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.	CMS
Surge Capacity - Physical Environment	CMS is waiving certain requirements under the Medicare conditions at 42 C.F.R. §482.41 and §485.623 to allow for flexibilities during hospital, psychiatric hospital, and CAH surges. CMS will permit non-hospital buildings/space to be used for patient care and quarantine sites provided that the location is approved by the state (ensuring safety and comfort for patients and staff are sufficiently addressed).	CMS
Surge Capacity - Physical Environment	CMS waived certain physical environment requirements under the Medicare conditions of participation at 42 CFR §482.41 and 42 CFR §485.623 to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and critical access hospitals (CAHs) as a result of COVID-19. CMS will permit facility and non-facility space that is not normally used	CMS

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	for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. States are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.	
Surge Capacity - Psychiatric Patients in Acute Care Units	Allows hospitals to relocate inpatients from excluded distinct part psychiatric unit to acute beds if beds and staff are appropriate for safe care. IPPS hospitals should bill for inpatient psychiatric services and document in the medical record that patient is in acute bed due to capacity or other exigent circumstances relating to the emergency.	CMS
Surge Capacity - Rehab Patients in Acute Care Units	Allows hospitals to relocate patients from excluded distinct part inpatient rehabilitation unit to acute beds if beds are appropriate for such patients and they continue to receive intensive rehab services. Hospitals should bill for rehab services under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS), and document in the medical record that patient is in acute bed due to capacity or other exigent circumstances relating to emergency. Also waives the 60% rule for IRFs for patients admitted solely to respond to the emergency.	CMS
Surge Capacity – Temporary Location: CAH	42 CFR §485.610{b), that the CAH be located in a rural area or an area being treated as rural, allowing the CAH flexibility in the establishment of surge site locations. CMS is also waiving the requirement at §485.610{e) regarding the CAH's off-campus and co-location requirements, allowing the CAH flexibility in establishing temporary off-site locations. To facilitate the establishment of CAHs without walls, these waivers will suspend restrictions on CAHs regarding their rural location and their location relative to other hospitals and CAHs. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS
Surge Capacity - Temporary Locations	Certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 and the provider based department requirements at §413.65 to allow hospitals to establish and operate as part of the hospital any location meeting those conditions of participation for hospitals that continue to apply during the public health emergency. The waiver also allows hospitals to change the status of their current provider-based department locations to the extent necessary to address the needs of hospital patients as part of the state or local pandemic plan. This extends to any entity operating as a hospital (whether a current hospital establishing a new location or an ASC enrolling as a hospital during the public health emergency pursuant to a streamlined enrollment and survey and certification process) so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.	CMS
Surge Capacity – Temporary Locations: EMTALA	CMS is waiving the enforcement of section 1867(a) of the Social Security Act (or EMTALA). This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness or pandemic plan.	CMS
Surge Capacity – Temporary Locations: EMTALA	CMS is waiving the enforcement of section 1867(a) of the Social Security Act (or EMTALA). This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, so long as it is not inconsistent with the state emergency preparedness or pandemic plan.	CMS
Surge Capacity - Written Policies and Procedures	42 CFR §482.12(f)(3), emergency services, with respect to surge facilities only, such that written policies and procedures for staff to use when evaluating emergencies are not required for surge facilities...These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS

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Survey Prioritization	For a three-week period only, CMS will prioritize (1) Complaint/facility-reported incident surveys; (2) Targeted Infection Control Surveys; and (3) Self-assessments. Further, standard surveys for hospitals--including the life safety code and emergency preparedness elements of those standard surveys and revisits that are not associated with immediate jeopardy (IJ)--will not be authorized. Also, for Clinical Laboratory Improvement Amendments (CLIA), CMS intends to prioritize IJ situations over recertification surveys, and to use enforcement discretion unless IJ situations arise.	CMS
Telemedicine	The provisions related to telemedicine at 42 CFR §482.12(a) (8)-(9) for hospitals and §485.616(c) for CAHs, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital.	CMS
Telemedicine	CMS broadened its prior telehealth waivers to waive the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2). The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.CMS waived the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services	CMS
Telemedicine	For as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: 1) The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;2) The telemedicine communication is conducted using an audio-visual, real-time, two way interactive communication system;3) The practitioner is acting in accordance with applicable Federal and State law	DEA
Utilization Review	Certain requirements under 42 CFR §482.l(a)(3) and 42 CFR §482.30 that address the statutory basis for hospitals and include the requirement that hospitals participating in Medicare and Medicaid must have a UR plan that meets specified requirements. The entire condition of participation UR at §482.30, which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.	CMS
Verbal Orders	CMS is waiving the requirements of §482.23, §482.24 and §485.635(d)(3). Specifically, the following provisions are waived:1) §482.23(c)(3)(i)- If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently2) §482.24(c)(2) - All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient3) §482.24(c)(3)- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders. This would include all subparts at §482.24(c)(3).4) §485.635(d)(3)- Although the regulation requires medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.	CMS