SUMMARY OF FEDERAL ACTIONS IN RESPONSE TO THE COVID-19 PANDEMIC

In response to the national emergency taking effect on March 1, 2020, and the public health emergency (PHE) taking effect on January 27, 2020, due to the COVID-19 pandemic, the legislature and various federal agencies have taken action to, among other purposes, offer health care providers, employers, business, and organizations certain flexibilities to ensure continued access to necessary health care and to relieve the financial burden on health care providers and other businesses to meet the increased demand for urgent health care.

The following is a summary of federal waivers, federal agency guidance, federal statutory provisions, and federal regulatory actions regarding changes to certain requirements applicable to health care providers, employers, and organizations enacted or implemented in response to the COVID-19 pandemic. The table below is organized by federal action and is also hyperlinked to the relevant source documents.

Please note this document captures the most relevant federal changes, but it is not exhaustive. This document was last updated on April 13, 2020. For additional information, please visit the Hall Render COVID-19 Resource Center at https://www.hallrender.com/coronavirus/ or contact Ritu Cooper at rcooper@hallrender.com or at (202) 370-9584.

COVID-19 EMERGENCY DECLARATION BLANKET WAIVERS FOR HEALTH CARE PROVIDERS (Issued March 13, 2020 and Mach 17, 2020, Revised on March 20, 2020, and Updated on April 3, 2020 and April 9, 2020)				
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3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	EMTALA Waiver	CMS is waiving the enforcement of section 1867(a) of the Social Security Act (the Emergency Medical Treatment and Active Labor 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.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Verbal Orders Waiver	CMS is waiving the requirements of §482.23, §482.24 and §485.635(d)(3) to allow for additional flexibilities related to verbal orders where read-back verification is still required but authentication may occur later than 48 hours. This will allow for more efficient treatment of patients in a surge situation.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Reporting Requirements Waiver	CMS is waiving the requirements at 42 C.F.R. §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 on the next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits. Due to current hospital surge, CMS is waiving this requirement to ensure hospitals are focusing on increased care demands and patient care.
3/1/20	CMS/HHS	Hospitals which are considered to be impacted by a	Waiver re Certain Patient Rights Requirements	CMS is waiving requirements under this section only for hospitals which are considered to be impacted by a widespread outbreak of COVID-19. Hospitals that are located in a State

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		widespread outbreak of COVID-19 (i.e., 6-50 or more confirmed cases)		which has widespread confirmed cases (i.e., 6-50 or more confirmed cases), as updated under the CDC States Reporting Cases of COVID- 19 to CDC
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Sterile Compounding Waiver	CMS is waiving these requirements in order 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. This will conserve scarce face mask supplies which will help with the impending shortage of medications. While USP797 also outlines this, CMS will not be reviewing the use and storage of facemasks under these requirements.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Detailed Information Sharing for Discharge Planning for Hospitals and CAHs Waiver	CMS is waiving the requirement to provide detailed information regarding discharge planning as outlined in 42 C.F.R. §482.43(a)(8), §482.61(e), and 485.642(a)(8)
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Limited Detailed Discharge Planning for Hospitals Waiver	CMS is waiving all the requirements and subparts 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.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Medical Staff Requirements Waiver	CMS is waiving requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at the hospital and for new physicians to be able to practice before full medical staff/governing body review and

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				approval to address workforce concerns related to COVID-19. CMS is waiving §482.22(a) (1)-(4) regarding details of the credentialing and privileging process. (Please also refer to Practitioner Locations Blanket Waiver listed below.)
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Medical Records Timing Waiver	CMS is waiving requirements under 42 CFR §482.24(a) through (c), which cover the subjects of the organization and staffing of the medical records department, requirements for the form and content of the medical record, and record retention requirements, and these flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. CMS is waiving §482.24(c)(4)(viii) related to medical records to allow flexibility in completion of medical records within 30 days following discharge from a hospital. This flexibility will allow clinicians to focus on the patient care at the bedside during the pandemic.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Flexibility in Patient Self Determination Act Requirements (Advance Directives) Waiver	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.
3/1/20	CMS/HHS	Hospitals, Psychiatric Hospitals, and CAHs	Physical Environment Requirements under 42 C.F.R. §482.41 and §485.623 Waiver	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

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				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). This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients.
3/1/20	CMS/HHS	Hospitals and CAHs	Telemedicine Requirements under 42 CFR §482.12(a) (8)–(9) for hospitals and §485.616(c) for CAHs Waivers	CMS is waiving 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. This allows for increased access to necessary care for hospital and CAH patients, including access to specialty care.
3/1/20	CMS/HHS	Hospitals	Physician Services Requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) Waiver	CMS is waiving requirements under 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4), which requires 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.
3/1/20	CMS/HHS	Hospitals, CAHs, and Ambulatory Surgical Centers (ASCs)	Anesthesia Services Requirements under 42 CFR §482.52(a)(5), §485.639(c)(2), and §416.42 (b)(2) Waiver	CMS is waiving requirements under 42 CFR §482.52(a)(5), §485.639(c) (2), and §416.42 (b)(2) that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician in paragraphs §482.52(a)(5) and §485.639(c)(2). CRNA supervision will be at the discretion of the hospital and state law. These waivers will allow CRNAs to function to the fullest extent of their licensure, and may be implemented so

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				long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
3/1/20	CMS/HHS	Hospitals	Utilization Review Requirements under 42 CFR §482.1(a)(3) and 42 CFR §482.30 Waiver	CMS is waiving certain requirements under 42 CFR §482.1(a)(3) and 42 CFR §482.30 which address the statutory basis for hospitals and includes the requirement that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements.
3/1/20	CMS/HHS	Surge Facilities	Written Policies and Procedures for Appraisal of Emergencies at Off Campus Hospital Departments Waiver	CMS is waiving 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. This removes the burden on facilities to develop and establish additional policies and procedures at their surge facilities or surge sites related to the assessment, initial treatment and referral of patients. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
3/1/20	CMS/HHS	Hospitals and CAHs	Emergency Preparedness Policies and Procedures Waiver	CMS is waiving 42 CFR §482.15(b) and §485.625(b), which requires the hospital and CAH to develop and implement emergency preparedness policies and procedures, and §482.15(c)(1)–(5) and §485.625(c)(1)–(5) 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

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				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, and removes the burden on facilities to establish these policies and procedures for their surge facilities or surge sites.
3/1/20	CMS/HHS	Hospitals and CAHs	Quality Assessment and Performance Improvement Program Waiver	CMS is waiving 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 (QAPI) programs (for hospitals that are part of a hospital system). These flexibilities, which apply to both hospitals and CAHs, may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. We expect any improvements to the plan to focus on the Public Health Emergency (PHE). While this waiver decreases burden associated with the development of a hospital or CAH QAPI program, the requirement that hospitals and CAHs maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. This waiver applies to both hospitals and CAHs.
3/1/20	CMS/HHS	Hospitals and CAHs	Nursing Services Requirements at 42 CFR §482.23(b)(4),	CMS is waiving the requirements at 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

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			§482.23(b)(7), and §485.635(d)(4)	establishing which outpatient departments are not required to have a registered nurse present. These waivers allow nurses increased time to meet the clinical care needs of each patient and allows for the provision of nursing care to an increased number of patients. In addition, CMS expects that hospitals will need relief for the provision of inpatient services and as a result, the requirement to establish nursing-related policies and procedures for outpatient departments is likely of lower priority. These flexibilities apply to both hospitals and CAHs §485.635(d)(4), and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
3/1/20	CMS/HHS	Hospitals	Food and Dietetic Services Requirements under 42 CFR §482.28(b)(3) Waiver	CMS is waiving the requirement at paragraph 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 capacity sites. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. Removing these administrative requirements will allow hospitals to focus more resources on providing direct patient care.
3/1/20	CMS/HHS	Hospitals	Respiratory Care Services Requirements under 42 CFR §482.57(b)(1) Waiver	CMS is waiving the requirements at 42 CFR §482.57(b)(1) that require 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

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				procedures. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. Not being required to designate these professionals in writing will allow qualified professionals to operate to the fullest extent of their licensure and training in providing patient care.
3/1/20	CMS/HHS	CAHs	CAH Personnel Qualifications Waiver	CMS is waiving 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.
3/1/20	CMS/HHS	CAHs	CAH Staff Licensure Waiver	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.

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3/1/20	CMS/HHS	CAHs	CAH Status and Location Waiver	CMS is waiving the requirement at 42 CFR §485.610(b) that the CAH be located in a rural area or an area being treated as being 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. In an effort 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.
3/1/20	CMS/HHS	CAHs	CAH Length of Stay Waiver	CMS is waiving the requirements that CAHs limit the number of beds to 25, and that the length of stay be limited to 96 hours under the Medicare conditions of participation for number of beds and length of stay at 42 CFR §485.620.
3/1/20	CMS/HHS	Hospitals and CAHs	Temporary Expansion Locations Waiver	For the duration of the PHE related to COVID-19, CMS is waiving certain requirements under the Medicare conditions of participation at 42 CFR §482.41 and §485.623 (as noted elsewhere in the waiver document) 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 PHE. This waiver also allows hospitals to change the status of their current provider-based

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				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 Ambulatory Surgical Center (ASC) enrolling as a hospital during the PHE 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. This waiver will enable hospitals to meet the needs of Medicare beneficiaries.
3/1/20	CMS/HHS	CAHs	Responsibilities of physicians in critical access hospitals (CAHs) Waiver of Requirements under 42 C.F.R. § 485.631(b)(2)	CMS is waiving the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH at § 485.631(b)(2). CMS is retaining the regulatory language in the second part of the requirement at § 485.631(b)(2) that a physician be available "through direct radio or telephone communication, or electronic communication for consultation, assistance with medical emergencies, or patient referral." Retaining this longstanding CMS policy and related longstanding subregulatory guidance that further described communication between CAHs and physicians will assure an appropriate level of physician direction and supervision for the services provided by the CAH. This will allow the physician to perform responsibilities remotely, as appropriate. This also allows CAHs to use nurse practitioners and physician assistants to the fullest extent

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				possible, while ensuring necessary consultation and support as needed.
3/1/20	CMS/HHS	RHCs & FQHCs	Certain Staffing Requirements under 42 C.F.R. 491.8(a)(6) Waiver	CMS is waiving the requirement in the second sentence of § 491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC and FQHC operates. CMS is not waiving the first sentence of § 491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.
3/1/20	CMS/HHS	RHCs & FQHCs	Physician supervision of NPs in RHCs and FQHCs Requirements under 42 C.F.R. 491.8(b)(1) Waiver	CMS is modifying the requirement that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

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3/1/20	CMS/HHS	IPPS Hospitals	Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units Waiver	Blanket waiver to inpatient prospective payment system (IPPS) hospitals that, as a result of the emergency, need to house acute care inpatients in excluded distinct part units, such as excluded distinct part unit IRFs or IPFs, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the emergency.
3/1/20	CMS/HHS	Acute Care Hospitals with Excluded Inpatient Psychiatric Units	Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital Waiver	CMS is allowing acute care hospitals with excluded distinct part inpatient psychiatric units to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit as a result of a disaster or emergency. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.
3/1/20	CMS/HHS	Acute Care Hospitals with	Care for Excluded Inpatient Rehabilitation	CMS is allowing acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of a disaster

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		Excluded Distinct Part Inpatient Rehabilitation Units	Unit Patients in the Acute Care Unit of a Hospital Waiver	or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit as a result of this PHE. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility (IRF) prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients, and such patients continue to receive intensive rehabilitation services.
3/1/20	CMS/HHS	IPPS and Other Acute Care Hospitals	Flexibility for Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule" Waiver	IRFs may exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, CMS would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.
3/1/20	CMS/HHS	IPPS Hospitals	Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix	CMS collects data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. Completed 2019 Occupational Mix Surveys, Hospital Reporting Form CMS-10079, for the Wage Index Beginning FY 2022, are due to the Medicare

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			Survey Submission Waiver	Administrative Contractors (MACs) on the Excel hospital reporting form available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html by July 1, 2020. CMS is currently granting an extension for hospitals nationwide affected by COVID-19 until 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.
3/1/20	CMS/HHS	Long-Term Care Acute Hospitals (LTCHs)	Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s	CMS has determined it is appropriate to issue a blanket waiver to long-term care hospitals (LTCHs) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.
3/1/20	CMS/HHS	Extended Neoplastic Disease Care Hospitals	Care for Patients in Extended Neoplastic Disease Care Hospitals Waiver	CMS is allowing extended neoplastic disease care hospitals to exclude inpatient stays where the hospital admits or discharges patients in order to meet the demands of the emergency from the greater than 20-day average length of stay 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)(1)(B)(vi) of the Act and §42 CFR 412.22(i).

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3/1/20	CMS/HHS	SNF	3-Day Prior Hospital Stay Waiver	Using the authority under Section 1812(f) of the Social Security Act, CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).
3/1/20	CMS/HHS	SNF	Reporting Minimum Data Set Requirements under 42 CFR 483.20 Waiver	This waiver provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities).
3/1/20	CMS/HHS	LTCFs	Staffing Data Submission Waiver	CMS is waiving 42 CFR 483.70(q) to provide relief to long term care facilities on the requirements for submitting staffing data through the Payroll- Based Journal system.
3/1/20	CMS/HHS	SNFs & NFs	Waiver of Pre-Admission Screening and Annual Resident Review (PASARR)	CMS is waiving the following requirements related to PASARR for nursing home residents who may also have a mental illness or intellectual disability (42 CFR §483.106(b)(4)).

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3/1/20	CMS/HHS	LTCFs, SNFs, NFs	Physical Environment Requirements under 42 CFR 483.90 Waiver	Provided that the State has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under §483.90 to allow for a non-SNF building to be temporarily certified as and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents which may not be feasible in the existing SNF structure to ensure care and services during treatment for COVID-19 is available while protecting other vulnerable adults. CMS is also waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.
3/1/20	CMS/HHS	LTCFs, SNFs, NFs	Resident Groups Waiver	CMS is waiving the requirements at §483.10(f)(5) which allow for residents to have the right to participate in-person in resident groups. This waiver would only permit the facility to restrict having in-person meetings during the national

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				emergency given the recommendations of social distancing and limiting gatherings of more than ten people. Refraining from in-person gatherings will help prevent the spread of COVID-19.
3/1/20	CMS/HHS	SNFs & NFs	Training and Certification of Nurse Aids Waiver	CMS is waiving the requirements at §483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which requires that a SNF and NF may not employ anyone for longer than 4 months unless they met the training and certification requirements under §483.35(d).
3/1/20	CMS/HHS	LTCFs, SNFs, NFs	Physician Visits in Skilled Nursing Facilities/Nursing Facilities Waiver	CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.
3/1/20	CMS/HHS	LTCFs, SNFs, NFs	Resident Roommates and Grouping Waiver	CMS is waiving the requirements in 42 CFR 483.10(e) (5), (6), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, to provide notice and rationale for changing a resident's room, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19

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				residents, to prevent the transmission of COVID-19 to other residents.
3/1/20	CMS/HHS	LTCFs, SNFs, and/or NFs	Resident Transfer and Discharge Waiver	CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i) (with some exceptions) to allow a long term care facility (LTCF) to transfer or discharge residents to another LTCF solely for the following cohorting purposes: 1. Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents; 2. Transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19; or 3. Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days. Exceptions: These requirements are only waived in cases that meets certain requirements.
3/1/20	CMS/HHS	LTCFs, SNFs, and/or NFs	Physician Services: Physician Delegation of Tasks in SNFs and	CMS is providing relief to long-term care facilities related to provision of physician services through the following actions:

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			Physician Visits Requirements under 42 C.F.R. 483.30(e)(4) and 42 C.F.R. 483.30(c)(3) Waiver	• Physician Delegation of Tasks in SNFs. 42 C.F.R. 483.30(e)(4). CMS is waiving the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 C.F.R. 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the State and is acting within the scope of practice laws as defined by State law. CMS is temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under State law or by the facility's own policy. • Physician Visits. 42 C.F.R. 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. CMS is modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical

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				nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws. • Note to Facilities. These actions will assist in potential staffing shortages, maximize the use of medical personnel, and protect the health and safety of residents during the PHE. We note that we are not waiving the requirements for the frequency of required physician visits at § 483.30(c)(1). As set out above, CMS has only modified the requirement to allow for the requirement to be met by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate. In addition, CMS noted that it is not waiving our requirements for physician supervision in § 483.30(a)(1), and the requirement at § 483.30(d)(3) for the facility to provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. It is important that the physician be available for consultation regarding a resident's care.
3/1/20	CMS/HHS	Home Health Agencies	Waiver Allowing Extension of Autocancellation Dates of RAPs	To ensure the correct processing of home health emergency related claims, Medicare Administrative Contractors (MACs) are allowed to extend the autocancellation date of Requests for Anticipated Payment (RAPs).

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3/1/20	CMS/HHS	Home Health Agencies	OASIS Transmission Reporting Waiver	Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. This waiver includes: • Extension of the 5-day completion requirement for the comprehensive assessment to 30 days. • Waives the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.
3/1/20	CMS/HHS	Home Health Agencies	Initial Assessments Waiver	CMS is waiving the requirements at 42 CFR §484.55(a) to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review.
3/1/20	CMS/HHS	Home Health Agencies	Onsite Visits for HHA Aide Supervision Waiver	CMS is waiving the requirements at 42 CFR §484.80(h), which require a nurse to conduct an onsite visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time. This waiver is also temporarily suspending the 2-week aide supervision by a registered nurse for home health agencies requirement at §484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.
3/1/20	CMS/HHS	Home Health Agencies	Allow Occupational Therapists (OTs) to Perform Initial and Comprehensive Assessment for All	CMS is waiving the requirement that OTs may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care. This temporary blanket modification allows OTs to perform the initial and

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			Patients Requirements under 42 C.F.R. 484.55(a)(2) and 484.55(b)(3) Waiver	comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether occupational therapy is the service that establishes eligibility. The existing regulations at § 484.55(a) and (b)(2) would continue to apply that OTs and other therapists would not be permitted to perform assessments in nursing only cases. We would continue to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice. Expanding the category of therapists who may perform initial and comprehensive assessments to include OTs provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services.
3/1/20	CMS/HHS	Hospice	Use of Volunteers Waiver	CMS is waiving the requirement that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and anticipated quarantine. (42 CFR §418.78(e)).
3/1/20	CMS/HHS	Hospice	Comprehensive Assessments Waiver	CMS is waiving certain requirements for Hospices (§418.54) related to update of the comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment (§418.54(d)). Hospices must

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				continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.
3/1/20	CMS/HHS	Hospice	Non-Core Services Waiver	CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at §418.72 for physical therapy, occupational therapy, and speech-language pathology.
3/1/20	CMS/HHS	Hospice	Onsite Visits for Hospice Aide Supervision Waiver	CMS is waiving the requirements at 42 CFR §418.76(h), which require a nurse to conduct an onsite supervisory visit every two weeks. This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.
3/1/20	CMS/HHS	Hospice	Hospice Aide Competency Testing Allow Use Of Pseudo Patients Requirements under 42 C.F.R. 418.76(c)(1) Waiver	CMS is temporarily modifying the requirement in § 418.76(c)(1) that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient. This modification allows hospices to utilize pseudo patients such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient. This increases the speed of performing competency testing and allows new aides to begin serving patients more quickly without affecting

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				patient health and safety during the public health emergency (PHE).
3/1/20	CMS/HHS	Hospice	12-Hour Annual In-Service Training Requirement for Hospice Aides Requirements under 42 C.F.R. 418.76(d) Waiver	CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period. This allows aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care.
3/1/20	CMS/HHS	ESRD Facilities	Training Program and Periodic Audits Waiver	CMS is waiving the requirement at 42 CFR §494.40(a) related to the condition on Water & Dialysate Quality, specifically that on-time periodic audits for operators of the water/dialysate equipment are waived to allow for flexibilities.
3/1/20	CMS/HHS	ESRD Facilities	Defer Equipment Maintenance & Fire Safety Inspections Waiver	CMS is waiving the requirement at 42 CFR §494.60(b) for on-time preventive maintenance of dialysis machines and ancillary dialysis equipment. Additionally, CMS is also waiving the requirements under §494.60(d) which requires ESRD facilities to conduct on-time fire inspections. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency.
3/1/20	CMS/HHS	ESRD Facilities	Emergency Preparedness Waiver	CMS is waiving the requirements at 42 CFR §494.62(d)(1)(iv) which requires ESRD facilities to demonstrate as part of their Emergency Preparedness Training and Testing Program, that staff can demonstrate that, at a minimum, its patient care staff maintains current CPR certification. CMS is waiving the requirement for maintenance of CPR certification during the

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				COVID-19 emergency due to the limited availability of CPR classes.
3/1/20	CMS/HHS	ESRD Facilities	Ability to Delay Some Patient Assessments Waiver	CMS is not waiving subsections (a) or (c) of 42 CFR §494.80, but is waiving the following requirements at 42 CFR §494.80(b) related to the frequency of assessments for patients admitted to the dialysis facility. CMS is waiving the "on-time" requirements for the initial and follow up comprehensive assessments within the specified timeframes as noted below. This waiver applies to assessments conducted by members of the interdisciplinary team, including: a registered nurse, a physician treating the patient for ESRD, a social worker, and a dietitian. These waivers are intended to ensure that dialysis facilities are able to focus on the operations related to the Public Health Emergency. Specifically, CMS is waiving: • §494.80(b)(1): An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. • §494.80(b)(2): A follow up comprehensive reassessment must occur within 3 months after the completion of the initial assessment to provide information to adjust the patient's plan of care specified in §494.90.

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3/1/20	CMS/HHS	ESRD Facilities	Time Period for Initiation of Care Planning and Monthly Physician Visits Waiver	CMS is modifying two requirements related to care planning, specifically: • 42 CFR §494.90(b)(2): CMS is modifying the requirement that requires the dialysis facility to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This modification will also apply to the requirement for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments. • §494.90(b)(4): CMS is modifying the requirement that requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and also recommends exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.
3/1/20	CMS/HHS	ESRD Facilities	Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation Waiver	CMS is waiving the requirement at 42 CFR §494.100(c)(1)(i) which requires the periodic monitoring of the patient's home adaptation, including visits to the patient's home by facility personnel. For more information on existing flexibilities for in-

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				center dialysis patients to receive their dialysis treatments in the home, or long-term care facility, reference QSO-20-19-ESRD.
3/1/20	CMS/HHS	ESRD Facilities	Home Dialysis Machine Designation – Clarification	The ESRD Conditions for Coverage (CFCs) do not explicitly require that each home dialysis patient have their own designated home dialysis machine. The dialysis facility is required to follow FDA labeling and manufacturer's directions for use to ensure appropriate operation of the dialysis machine and ancillary equipment. Dialysis machines must be properly cleaned and disinfected to minimize the risk of infection based on the requirements at 42 CFR §494.30 Condition: Infection Control if used to treat multiple patients.
3/1/20	CMS/HHS	ESRD Facilities	Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded	CMS authorizes the establishment of SPRDFs under 42 CFR §494.120 to address access to care issues due to COVID-19 and the need to mitigate transmission among this vulnerable population. This will not include the normal determination regarding lack of access to care at §494.120(b) as this standard has been met during the period of the national emergency. Approval as a SPRDF related to COVID-19 does not require Federal survey prior to providing services.
3/1/20	CMS/HHS	ESRD Facilities	Dialysis Patient Care Technician (PCT) Certification	CMS is modifying the requirement at 42 CFR §494.140(e)(4) for dialysis PCTs that requires certification under a state certification program or a national commercially available certification program within 18 months of being hired as a dialysis PCT for newly employed patient care technicians. CMS is aware of the challenges that PCTs are facing with the

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				limited availability and closures of testing sites during the time of this crisis. CMS will allow PCTs to continue working even if they have not achieved certification within 18 months or have not met on time renewals.
3/1/20	CMS/HHS	ESRD Facilities	Transferability of Physician Credentialing	CMS is modifying the requirement at 42 CFR §494.180(c)(1) which requires that all medical staff appointments and credentialing are in accordance with state law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists. These waivers will allow physicians that are appropriately credentialed at a certified dialysis facility to function to the fullest extent of their licensure to provide care at designated isolation locations without separate credentialing at that facility, and may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan.
3/1/20	CMS/HHS	ESRD Facilities	Expanding availability of ESRD to Nursing Home Residents	CMS is waiving the following requirements related to Nursing Home residents: • Furnishing dialysis services on the main premises: ESRD requirements at 42 CFR §494.180(d) require dialysis facilities to provide services directly on its main premises or on other premises that are contiguous with the main premises. CMS is waiving this requirement to allow dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility. CMS continues to require that services provided to these

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				nursing home residents are under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility. Further, in order to ensure that care is safe, effective and is provided by trained and qualified personnel, CMS requires that the dialysis facility staff: furnish all dialysis care and services, provide all equipment and supplies necessary, maintain equipment and supplies in the nursing home, and complete all equipment maintenance, cleaning and disinfection using appropriate infection control procedures and manufacturer's instructions for use.
3/1/20	CMS/HHS	ESRD Facilities	Clarification for billing procedures	Typically, ESRD beneficiaries are transported from a SNF/NF to an ESRD facility to receive renal dialysis services. In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition. The ESRD provider would need to have their trained personnel administer the treatment in the SNF/NF. In addition, the

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				provider must follow the CFCs. In particular, under the CFCs is the requirement that to use a dialysis machine, the FDA-approved labeling must be adhered to § 494.100 and it must be maintained and operated in accordance with the manufacturer's recommendations (§ 494.60) and follow infection control requirements at § 494.30.
3/1/20	CMS/HHS	DMEPOS Suppliers	Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by the Emergency Waiver	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME MACs to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency. For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster Fact Sheet.
3/1/20	CMS/HHS	Certain Medicare Practitioners	Practice Location Waiver	CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met: 1) must be enrolled as such in the Medicare program; 2) must

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				possess a valid license to practice in the state which relates to his or her Medicare enrollment; 3) is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and, 4) is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area. In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the state. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.
3/1/20	CMS/HHS	Medicare Providers and Suppliers	Provider Enrollment Waiver	• 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

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				facilities to enroll and receive temporary Medicare billing privileges. • Waive the following screening requirements: o Application Fee - (to the extent applicable). o Criminal background checks associated with fingerprint-based criminal background checks (FCBC) (to the extent applicable) - 42 CFR §424.518. o 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.
3/1/20	CMS/HHS	Medicare Providers and Suppliers	Medicare Appeals in Fee For Service (FFS), Medicare Advantage (MA) and Part D	• 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), as well as the MA and Part D Independent Review Entities

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				(IREs) under 42 CFR §422.562, 42 CFR §423.562, 42 CFR §422.582 and 42 CFR §423.582, to allow 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 is allowing MACs and QICs in the FFS program under 42 CFR §405.910 and MA and Part D plans, as well as the MA and Part D IREs, to process an appeal even with incomplete Appointment of Representation forms as outlined under 42 CFR §422.561 and 42 CFR §423.560. However, any communications will only be sent to the beneficiary. • CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs, to process requests for appeals that do not meet the required elements using information that is available as outlined within 42 CFR §422.561 and 42 CFR §423.560. • CMS is allowing MACs and QICs in the FFS program under 42 CFR §405.950 and 42 CFR §405.966 (also including MA and Part D plans), as well as the MA and Part D IREs under 42 CFR §422.562 and 42 CFR

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				§423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.
3/1/20	CMS/HHS	Part B Drug Dispenser	Replacement Prescription Fills	Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable or unavailable due to the emergency.
MEDICARE FEE-FOR-SERVICE (FFS) RESPONSE TO THE PUBLIC HEALTH EMERGENCY FLEXIBILITIES AND POLICIES & PROCEDURES WITHOUT § 1135 WAIVERS				