Agency	Waiver	Applies To
DC Health	1. DC Health Administrative Order 2020 2. Mayor's Order 2020-046 3. Public Emergency Amendment Act of 2002 - DC Code: 2304.01(d) 4. Uniform Emergency Volunteer Health Practitioners Act of 2010 – DC Code: 2361.01 et seq. While the Public Health Emergency is in place: • Any health care provider who is licensed in their home jurisdiction in their field of expertise who is providing health care to District residents is deemed a temporary agent of the District for the duration of the order. Limitations: The health care provider can only provide health care services to individuals at licensed health care facilities located in the District (including telehealth). OR If the health care provider has an existing relationship with a patient who has returned to the District and the health care provider is providing continuity of services to the patient via telehealth. The health care facility utilizing the temporary agent must verify their credentials and license status to ensure compliance. A process must be in place that verifies the credentials and licensure status routinely during the emergency. The health care facility is responsible to ensure proper supervision. The health care facility must maintain a list of all temporary agents and be made available to DC Health for inspection upon demand. Data elements include name, profession, practice locations(s).	All licensed, registered or certified professionals
CMS	EMTALA Section 1867(a) screening patients at location offsite from hospital campus to prevent spread of COVID-19	Hospitals, Psychiatric Hospitals, and Critical Access Hospitals, including Cancer Centers and Long-Term Care Hospitals
CMS	Verbal Orders 42 CFR §482.23, §482.24 and §485.635(d)(3), specifically the following requirements are waived: §482.23(c)(3)(i); §482.24(c)(2); §482.24(c)(3); §485.635(d)(3)	Hospitals, practioners
CMS	Reporting Requirements 42 CFR §482.13(g) (1)(i)-(ii), which require that hospitals report patients in an intensive care unit whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/lvs	Hospitals
CMS	Condition of Participation Patient Rights- 42 CFR §482.13, under this waiver hospitals heavily impacted by COVID-19 would not be required to meet these requirements: honor timeframes for providing medical records; have written visiting policies; comply with seclusion requirements	Only hospitals that are considered to be impacted by a widespread outbreak of COVID-19
CMS	Sterile Compounding- 42 CFR; §482.25(b)(1) and §485.635(a)(3) allows 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	Hospitals, psychiatric hospitals
CMS	Detailed Information Sharing for Discharge Planning for Hospitals and CAHs 42 CFR §482.43(a)(8), §482.61(e), and §485.642(a)(8) to waive requirement to provide detailed information related to post-acute placement	Hospitals, critical access hospitals
CMS	Limiting Detailed Discharge Planning for Hospitals - all the requirements and subparts at 42 CFR §482.43(c) related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings are waived	Hospitals, HHAs, SNFs, IRFs, or LTCHs
CMS	Medical Staff Privileges 42 CFR §482.22(a)(1)-(4) wavier will 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 approval to address workforce concerns related to COVID-19	Hospitals, psychiatric hospitals
CMS	Medical Records Timing — 42 CFR 482.24(c)(4)(viii) and 485.638(a)(4)(iii) to allow flexibility in completion of medical records within 30 days following discharge	Hospitals, psychiatric hospitals

CMS	Flexibility in Patient Self Determination Act Requirements (Advance Directives) sections 1902(a)(58) and 1902(w)(1)(A) of the Act (for Medicaid); 1852(i) of the Act (for Medicare Advantage); and 1866(f) of the Act and 42 CFR §489.102 (for Medicare) to allow for staff to more efficiently deliver care to a larger number of patients.	
CMS	Physical Environment 42 CFR §482.41 and §485.623 to allow for flexibilities during hospital, psychiatric hospital, and CAH surges. Will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided location is approved by State	Hospitals, psychiatric hospitals
CMS	Telemedicine 42 CFR §482.12(a)(8)–(9) for hospitals and §485.616(c) for CAHs to allow for increased access to necessary care for hospital and CAH patients, including access to specialty care	Hospitals, Physicians, Nursing Homes
CMS	Physician Services 42 CFR §482.12(c)(1)–(2) and §482.12(c)(4) to allow hospitals to use other practitioners to the fullest extent possible	
CMS	Anesthesia Services 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) to allow CRNAs to function to the fullest extent of their licensure	Hospitals
CMS	Utilization Review 42 CFR §482.1(a)(3) and 42 CFR §482.30 -- 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.	
CMS	Written Policies and Procedure for Appraisal of Emergencies at Off Campus Hospital Departments 42 CFR §482.12(f)(3) to remove the burden on facilities to develop and establish additional policies and procedures at their surge facilities and sites	Emergency services, with respect to surge facilities ONLY
CMS	Emergency Preparedness Policies and Procedures 42 CFR §482.15(b) and §485.625(b) and §482.15(c)(1)–(5) and §485.625(c)(1)–(5)	Hospitals and CAHs
CMS	Quality Assessment and Performance Improvement Program 42 CFR §482.21(a)–(d) and (f), and §485.641(a), (b), and (d)	Hospitals and CAHs
CMS	Nursing Services 42 CFR §482.23(b)(4) and §482.23(b)(7) to 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.	Hospitals and CAHs
CMS	Food and Dietetic Services 42 CFR §482.28(b) (3) to allow hospitals to focus more resources on providing direct patient care.	Hospitals
CMS	Respiratory Care Services 42 CFR §482.57(b)(1) to allow qualified professionals to operate to the fullest extent of their licensure and training in providing patient care.	
CMS	CAH 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) allow CAHs to employ individuals in these roles who meet state licensure requirements and provide maximum staffing flexibility.	
CMS	CAH Staff Licensure 42 CFR §485.608(d) to provide maximum flexibility for CAHs to use all available clinicians.	
CMS	CAH Status and Location 42 CFR §485.610(b) and §485.610(e) to allow the CAH flexibility in establishing temporary off-site locations.	
CMS	CAH Length of Stay 42 CFR §485.620	
CMS	Temporary Expansion Locations 42 CFR §482.41 and §485.623 and §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. And also to allow 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.	

CMS	Housing Acute Care Patients in the IRF or Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units	IPFs
CMS	Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital	Hospitals
CMS	Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital	Hospitals
CMS	Flexibility for Inpatient Rehabilitation Facilities Regarding the “60 Percent Rule”	Inpatient Rehabilitation Facilities
CMS	Extension for Inpatient Prospective Payment System (IPPS) Wage Index Occupational Mix Survey Submission	Hospitals
CMS	Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)	Long-Term Care Acute Hospitals
CMS	Care for Patients in Extended Neoplastic Disease Care Hospitals	Hospitals
CMS	3- Day Prior Hospitalization under Section 1812(f)	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Reporting Minimum Data Set 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Staffing Data Submission 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.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Waive Pre-Admission Screening and Annual Resident Review (PASARR) 42 CFR 483.20(k) allowing states and nursing homes to suspend these assessments for new residents for 30 days.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Physical Environment 42 CFR 483.90, specifically § 483.90 to allow for a non-SNF building to be temporarily certified and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents and 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.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Resident Groups 42 CFR 483.10(f)(5) would only permit the facility to restrict in-person meetings during the national emergency.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Training and Certification of Nurse Aides 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)) to assist in potential staffing shortages.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Physician Visits in Skilled Nursing Facilities/Nursing Facilities 42 CFR 483.30 to allow physicians and non-physicians to perform telehealth visits.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Resident roommates and grouping 42 CFR 483.10€ (5), (6), and (7) to follow CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents.	Long-Term Care Facilities and Skilled Nursing Facilities
CMS	Resident Transfer and Discharge 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 (LTC) facility to transfer or discharge residents to another LTC facility.	Long-Term Care Facilities and Skilled Nursing Facilities

CMS	CMS allowing Medicare Administrative Contractors (MACs) to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.	Home Health Agencies
CMS	CMS is providing relief to HHAs on the timeframes related to OASIS Transmission by extending the 5-day completion requirement to 30 days and waiving the 30-dat OASIS submission requirement.	Home Health Agencies
CMS	Initial Assessments 42 CFR §484.55(a) to allow patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and longterm care facilities.	Home Health Agencies
CMS	Waive Onsite visits for HHA Aide Supervision 42 CFR §484.80(h) to waive 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.	Home Health Agencies
CMS	Waive Requirement for Hospices to Use Volunteers 42 CFR §418.78(e)	Hospice
CMS	Comprehensive Assessments 42 CFR §418.54 this requires Hospices continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.	Hospice
CMS	Waive Non-Core Services 42 CFR §418.72 that requires hospices to provide certain non-core hospice services (physical therapy, occupational therapy, and speech-langugage pathology).	Hospice
CMS	Waived Onsite Visits for Hospice Aide Supervision 42 CFR §418.76(h) which waives 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.	Hospice
CMS	Training Program and Periodic Audits 42 CFR §494.40(a) to allow for flexibilities.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Defer Equipment Maintenance & Fire Safety Inspections 42 CFR §494.60(b) to ensure that dialysis facilities are able to focus on the operations related to COVID.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Emergency Preparedness 42 CFR §494.62(d)(1)(iv) to waive the requirement for maintenance of CPR certification during the COVID-19 emergency due to the limited availability of CPR classes.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Ability to Delay Some Patient Assessments 42 CFR §494.80(b) which 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. Specifically CMS is waiving §494.80(b)(1) and §494.80(b)(2).	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Time Period for Initiation of Care Planning and Monthly Physician Visits 42 CFR §494.90(b)(2) modifying the requirement that requires the dialysis facilty to implement the initial plan of care within the latter of 30 calendar days after admission and §494.90(b)(4) to modify the requirement that requires the ESRD facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant at least monthly.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Dialysis Home Visits to Assess Adaptation and Home Dialysis Machine Designation 42 CFR §494.100(c)(1)(i) which allows facility personnel to not visit patient's homes.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Home Dialysis Machine Designation- Clarification 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.	End-Stage Renal Dialysis (ESRD) Facilities

CMS	Special Purpose Rental Dialysis Facilities (SPRDF) Designation Expanded - establishments of SPRDFs are authorized under 42 CFR §494.120	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Dialysis Patient Care Technician (PCT) Certification - modifying 42 CFR §494.140(e)(4)	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Transferability of Physician Credentialing- modifying 42 CFR §494.140(e)(4) to 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.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Expanding availability of ESRD to Nursing Home Residents 42 CFR §494.180(d) to allow dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility.	End-Stage Renal Dialysis (ESRD) Facilities
CMS	Clarification for billing procedures 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).	End-Stage Renal Dialysis (ESRD) Facilities
CMS	When DMEPOS is lost, destroyed, damaged, etc. MACs allowed to waive replacement requirements like the face-to-face requirement, new physician's order, and new medical necessity documentation are not required.	MACs and DMEPOS
CMS	Practitoner Locations - 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. The following four requirements must be met for this waiver: 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) 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.	Practitoner Locations
CMS	Waived 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. This waiver also • 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.	Provider Enrollment
CMS	Medicare Appeals in Fee for Service (FFS), Medicare Advantage (MA) and Part D-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.	MACs and QICs in the FFS program
CMS	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.	MACs and QICs in the FFS program
CMS	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 §423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.	MACs and QICs in the FFS program
CMS	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 §423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.	MACs and QICs in the FFS program

CMS	1135 Waivers	
CMS	Temporarily suspend Medicaid fee-for-service prior authorization requirements- Section 1135(b)(1)(C) allows for a waiver or modification of pre-approval requirements, including prior authorization processes required under the State Plan for particular benefits.	
CMS	Extend pre-existing authorizations for which a beneficiary has previously received prior authorization through the end of the public health emergency- 1135(b)(1)(C) of the Act that allow for waiver or modification of pre-approval requirements to permit services approved to be provided on or after March 1, 2020, to continue to be provided without a requirement for a new or renewed prior authorization, through the termination of the public health emergency, including any extensions (up to the last day of the emergency period under section 1135(e) of the Act), for beneficiaries with a permanent residence in the geographic area of the public health emergency declared by the Secretary.	
CMS	Suspend Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessments for 30 days- Section 1919(e)(7) of the Act allows Level I and Level II assessments to be waived for 30 days.	
CMS	Provider Enrollment to allow that for the duration of the public health emergency, the District of Columbia may reimburse out-of-state providers for multiple instances of care to multiple participants. With respect to providers not already enrolled with another SMA or Medicare, CMS will waive the following screening requirements under 1135(b)(1) and (b)(2) of the Act, so the state may provisionally, temporarily enroll the providers for the duration of the public health emergency: Payment of the application fee - 42 C.F.R. §455.460. Criminal background checks associated with Fingerprint-based Criminal Background Checks - 42 C.F.R. §455.434. Site visits - 42 C.F.R. §455.432. In-state/territory licensure requirements - 42 C.F.R. §455.412	
CMS	Provision of Services in Alternative Settings 1135(b)(1) of the Act to allow facilities, including NFs, intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDDs), psychiatric residential treatment facilities (PRTFs), and hospital NFs, to be fully reimbursed for services rendered to an unlicensed facility provided that the state makes a reasonable assessment that the facility meets minimum standards.	
CMS	State Plan Amendment Flexibilities: Submission Deadline and Public Notice. The District of Columbia also requested a modification of the requirement to submit SPAs related to the COVID-19 emergency by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 C.F.R. §430.20. CMS is approving this request pursuant to section 1135(b)(5) of the Act. This approval applies only with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to alternative benefit plans (ABPs) to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof).	
CMS	Allow occupational therapists (OTs) to perform initial and comprehensive assessment for all patients. 42 C.F.R. 484.55(a)(2) and 484.55(b)(3)	
CMS	Hospice aide competency testing allow use of pseudo patients. 42 C.F.R. 418.76(c)(1) to 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.	HHA
CMS	12-hour annual in-service training requirement for hospice aides. 42 C.F.R. 418.76(d) to allow aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care.	Hospice
CMS	Certain staffing requirements. 42 C.F.R. 491.8(a)(6) assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.	FQHC
CMS	Physician supervision of NPs in RHCs and FQHCs. 42 C.F.R. 491.8(b)(1) allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.	FQHC

CMS	Site Neutral Payment Rate Provisions section 1886(m)(6) of the Social Security Act relating to certain site neutral payment rate provisions for long-term care hospitals (LTCHs). Section 3711(b)(1) of the CARES Act waives the payment adjustment under section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a discharge payment percentage (DPP) for the period that is at least 50 percent during the COVID-19 public health emergency period. Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site neutral payment rate under section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the public health emergency and occur during the COVID-19 public health emergency period. Under this provision, all LTCH cases admitted during the COVID-19 public health emergency period will be paid the relatively higher LTCH PPS standard Federal rate.	Long-term Care Hospitals
CMS	Inpatient Rehabilitation Facility – Intensity of Therapy Requirement (“3-Hour Rule”) waived 42 CFR § 412.622(a)(3)(ii) which provides that payment generally requires that patients of an inpatient rehabilitation facility receive at least 15 hours of therapy per week.	Inpatient Rehabilitation Facilities