2025 Southern California Wildfires Available Waivers in the State of California Health Care Providers

CMS is empowered to take proactive steps to help providers through waivers issued pursuant to section 1135 of the Social Security Act (the Act). In addition, discretionary SNF coverage is permitted under section 1812(f) of the Act, and extended coverage is permitted until the end of March 2025 for certain telehealth services. The following blanket waivers and other flexibilities are available to affected providers as needed, retroactively from 01/07/2025 through the end of the 2025 Southern California Wildfires public health emergency declaration for the State of California signed 01/10/2025 or when no longer needed. Despite the availability of blanket waivers, suppliers and providers should strive to return to their normal practice as soon as possible.

Blanket waivers DO NOT need to be submitted via the CMS 1135 Waiver Portal (https://cmsqualitysupport.servicenowservices.com/cms_1135) or via notification to the CMS Survey & Operations Group and are applied automatically by surveyors.

Hospitals, Psychiatric Hospitals, including Cancer Centers and Long-Term Care Hospitals (LTCHs)

- **Emergency Medical Treatment & Labor Act (EMTALA).** CMS is waiving the enforcement of section 1867(a) of the Act to allow hospitals and psychiatric hospitals to screen patients at a location offsite from the hospital's campus, so long as such screening is not inconsistent with a state's emergency preparedness plan or pandemic plan.

- **Medical Staff.** CMS is waiving requirements under 42 CFR §482.22(a)(1)-(4) to allow for physicians whose privileges will expire to continue practicing at a hospital and for new physicians to be able to practice before full medical staff/governing body review and approval, in order to address workforce concerns.

- **Physical Environment.** CMS is waiving **certain** physical environment requirements under the hospital, psychiatric hospital, and critical access hospital conditions of participation at 42 CFR §482.41 to allow increased flexibilities for surge capacity. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, 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 [1].

- **Telemedicine.** CMS is waiving the provisions related to telemedicine at 42 CFR §482.12(a)(8)– (9) for hospitals, 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 patients, including access to specialty care.

Temporary Expansion Locations. CMS is waiving certain physical environment requirements under 42 CFR §482.41 (as noted elsewhere in this waiver document) and the provider-based department location requirements at §413.65(e)(3) to allow hospitals to establish and operate as part of the hospital and location meeting those conditions of participation for hospitals, including any existing provider-based departments of the hospital. This extends to any entity operating as a hospital so long as the relevant location meets the conditions of participation and other requirements not waived by CMS.

Expanded Ability for Hospitals to Offer Long-term Care Services ("Swing-Beds") for Patients Who do not Require Acute Care but do Meet the Skilled Nursing Facility (SNF) Level of Care Criteria as Set Forth in 42 CFR 409.31. Under section 1135(b)(1) of the Act, CMS is waiving the eligibility requirements at 42 CFR 482.58(a)(1)-(4), "*Special Requirements for hospital providers of long-term care services ('swing-beds')"* 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 for this waiver, hospitals must:

- Not use SNF swing beds for acute-level care.
- Comply with all other hospital conditions of participation and those SNF provisions set out at 42 CFR 482.58(b) to the extent not waived.
- Be consistent with the state's emergency preparedness or pandemic plan.

[1] Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC* decision, States are obligated to offer/provide discharge planning and/or case management/ transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services/ case management and/or discharge planning would be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit.

Housing Acute Care Patients in the Inpatient Rehabilitation Facility (IRF) Excluded Distinct Part Units

Flexibility for Inpatient Rehabilitation Facilities Regarding the "60 Percent Rule"

- CMS is allowing IRFs to exclude patients from the freestanding hospital's or excluded distinct part 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, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

Housing Acute Care Patients in the Inpatient Psychiatric Facility (IPF) Excluded Distinct Part Units

Housing Acute Care Patients in Excluded Distinct Part Units

- CMS is allowing acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute inpatient care. The Inpatient Prospective Payment System (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 disaster or emergency.

Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)

- **Reporting Minimum Data Set (MDS).** CMS is modifying the requirements at 42 CFR §483.20(b)(2) to provide relief to SNFs on the timeframes in which they must conduct a comprehensive assessment and collect MDS data. CMS is not waiving the requirements for facilities to conduct the assessment and collect MDS data at 42 CFR 483.20(b)(1).

- **Waive Pre-Admission Screening and Annual Resident Review (PASARR).** CMS is waiving 42 CFR § 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed postadmission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to the State PASARR program for Level 2 Resident Review.

Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCHs)

- CMS is waiving long-term care hospitals' (LTCHs) the 25-day average length of stay requirement at § 412.23(e)(2) if an LTCH admits or discharges patients in order to meet the demands of the emergency.

Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

- **3-Day Prior Hospitalization.** Using the authority under Section 1812(f) of the Act, CMS may cover SNF stays without a 3-day prior inpatient hospitalization. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes a one-time renewal of SNF coverage without first having to start a new benefit period (this portion of the 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).

- **Physician Visits in Skilled Nursing Facilities/Nursing Facilities.** 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.

- **Physical Environment.** CMS is 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 and 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.

Hospice

- **Comprehensive Assessments.** CMS is modifying certain requirements at 42 CFR §418.54 related to updating comprehensive assessments of patients. This modifies the timeframes for updates to the comprehensive assessment found at §418.54(d). Hospices must continue to complete other required assessments (i.e., initial and ad-hoc assessments based on a change in the patient's condition); however, the timeframes for updating the comprehensive assessment may be extended from 15 to 21 days.

Home Health Agencies (HHAs)

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS Transmission through the following actions below**:**
    - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
    - Modifying the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.

- **Initial Assessments.** 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. This will allow patients to be cared for in the best environment for them while reducing the impact on acute care and long- term care facilities. This will allow for maximizing coverage by already scarce physician, and advanced practice clinicians, and allow those clinicians to focus on caring for patients with the greatest acuity.

- **Allow Physical Therapists (PTs), and Speech Language Pathologists (SLPs)** to perform Initial and Comprehensive Assessments for all Patients: CMS is waiving the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary waiver will allow any rehabilitation professional (PT, or SLP) to perform the initial and 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 or not the service establishes eligibility for the patient to be receiving home care.

- **CMS is waiving the requirements at CFR 418.76(h)(1) and CFR 418.76(h)(2) for Hospice and 42 CFR §484.80(h)(1) for HHAs**, 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 two-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. All postponed annual onsite assessments (direct observation) for each aide that provides services on behalf of the agency must be completed by these professionals no later than 60 days after the expiration of the PHE.

End-Stage Renal Dialysis (ESRD) Facilities

- **Ability to Delay Some Patient Assessments.** CMS 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.
- **Time Period for Initiation of Care Planning and Monthly Physician Visits.** 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, as evidenced by a monthly progress note placed in the medical record, 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.
- **Requirements that physicians or other health care professionals**, including dialysis technicians, hold licenses in the State in which they provide services is being waived if they have an equivalent license from another State (and are not affirmatively barred from practice in that State or any State a part of which is included in the emergency area).

- **Special Purpose Renal Dialysis Facilities (SPRDF) Designation Expanded.** CMS authorizes the establishment of SPRDFs to furnish dialysis under 42 CFR §494.120 to address access to care issues for kidney disease patients under emergency circumstances. 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 Special Purpose Renal Dialysis Facility related to Hurricane Milton does not require a Federal survey before providing services.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

- **Staffing Flexibilities.** CMS is waiving the requirements at 42 CFR §483.430(c)(4), which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. DSS performs activities such as cleaning the facility, cooking, and laundry services. DSC performs activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. During the time of this waiver, DCS may be needed to conduct some of the activities normally performed by the DSS. This will allow facilities to adjust staffing patterns while maintaining the minimum staffing ratios required at §483.430(d)(3).

- **Physical Environment.** CMS is waiving **certain** physical environment requirements under the ICF/IID conditions of participation at 42 CFR §483.470 to allow increased flexibilities for surge capacity. CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, 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.[2]

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

- When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, CMS is allowing DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacement requirements such that the face-to-face requirement, a new physician's

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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.

This also allows CMS to temporarily extend the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30 business days to provide notice to the Competitive Bidding Implementation Contractor of any subcontracting arrangements. CMS will notify DMEPOS Competitive Bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. Note: CMS will provide notice of any changes to reporting timeframes for future events.

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 by damage due to the disaster or emergency.

Provider Enrollment

- Providers and Suppliers who have been affected by the emergency in the impacted state, including SNFs, will be granted revalidation due date extensions until May 2025.

Modification of 60-Day Limit for Substitute Billing Arrangements (Locum Tenens)

CMS is modifying the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Without this flexibility, the regular physician or physical therapist generally could not use a single substitute for a continuous period of longer than 60 days, and would instead be required to secure a series of substitutes to cover sequential 60-day periods. The modified timetable applies to both types of substitute billing arrangements under Medicare fee-for-

service (i.e., reciprocal billing arrangements and fee-for-time compensation arrangements (formerly known as locum tenens)).

Notes: Under the Medicare statute, only 1) physicians and 2) physical therapists who furnish outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area can receive Medicare fee-for-service payment for services furnished by a substitute under a substitute billing arrangement. In addition, Medicare can pay for services under a substitute billing arrangement only when the regular physician or physical therapist is unavailable to provide the services. Finally, as provided by law, a regular physician or physical therapist who has been called or ordered to active duty as a member of a reserve component of the Armed Forces may continue to use the same substitute for an unlimited time even after the emergency ends.