Washington State Wildfires– Available Waivers for Washington State Health Care Providers

CMS is empowered to take proactive steps to help providers located in the declared emergency area through waivers issued pursuant to section 1135 of the Social Security Act (the Act). The following blanket waivers, modifications and other flexibilities are in effect through the end of the Washington State Wildfires Public Health Emergency (PHE) declaration signed 08/07/2026, retroactively from 08/01/2026, 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.

Medical and Other Health Services

- **Audio-Only Telehealth for Certain Services.** Pursuant to authority granted under 1135(b)(8), CMS is waiving the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR § 410.78(a)(3) for the use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services. Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

- **Eligible Telehealth Practitioners.** CMS is waiving the requirements of section 1834(m)(4)(E) of the Social Security Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners who may bill for their services when furnished as Medicare telehealth services from a distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. As a result, a broader range of practitioners, such as physical therapists, occupational therapists, and speech language pathologists can use telehealth to provide many Medicare services.

- **Medicare Telehealth - Originating Sites**. CMS is waiving certain Medicare telehealth payment requirements to allow beneficiaries in all areas of the country to receive telehealth services, including at their home. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services.

- **Hospitals Classified as Sole Community Hospitals (SCHs).** CMS is waiving certain eligibility requirements at 42 CFR § 412.92(a) for hospitals classified as SCHs prior to the PHE. Specifically, CMS is waiving the distance requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92, and is also waiving the "market share" and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii). CMS is waiving these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity.

- **Hospitals Classified as Medicare-Dependent, Small Rural Hospitals (MDHs).** For hospitals classified as MDHs prior to the PHE, and hospitals that became newly classified as MDHs during the PHE without the application of this waiver, CMS is waiving the eligibility requirement at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR § 412.108(a)(1)(iv)(C) that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods. MACs will resume their standard practice for evaluation of all eligibility requirements after the conclusion of the PHE period.

- **Reporting Requirements.** CMS is waiving reporting requirements at 42 CFR § 482.13(g)(1)(i)-(ii) to allow hospitals additional time 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. Temporarily, these deaths may be reported later than close of business next business day, provided any death where the restraint may have contributed is continued to be reported within standard time limits.

- **Utilization Review.** CMS is waiving certain requirements under 42 CFR § 482.30 that require that hospitals participating in Medicare and Medicaid to have a utilization review plan that meets specified requirements. CMS is waiving the entire Utilization Review CoP at 42 CFR § 482.30, which requires that a hospital must have a utilization review (UR) plan with an UR committee that provides for review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities have been implemented so long as they have not been inconsistent with a state or pandemic/emergency plan.

- **Written policies and procedures for appraisal of emergencies at off campus hospital departments.** CMS is waiving 42 CFR § 482.12(f)(3) related to emergency services, with respect to the surge facility(ies) 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 have been implemented so long as they have not been inconsistent with a state's emergency preparedness or pandemic plan.

- **Nursing Services.** 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 requires the hospital to have policies and procedures in place 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 allow for the provision of nursing care to an increased number of patients. These flexibilities apply to both hospitals and CAHs, and have been implemented so long as they have not been inconsistent with a state or pandemic/emergency plan.

- **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.

- **Temporary Expansion Location for CAHs.** 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 temporary 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. We are also temporarily suspending restrictions on CAHs regarding their location relative to other hospitals and CAHs consistent with a state's emergency preparedness or pandemic plan.

- **Temporary Expansion Locations.** CMS is waiving the requirements at 42 CFR § 491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. This flexibility includes areas which may be outside of the location requirements at 42 CFR § 491.5(a)(1) and (2) but will end after the PHE.

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.

Long Term Care/Skilled Nursing Facilities

- **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.

- **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).

- **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.

Home Health Agencies (HHAs)

- **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 supporting infection control and reducing impact on acute care and long-term care facilities, and allow clinicians to focus on caring for patients with the greatest acuity.

- **12-hour Annual In-service Training Requirement for Home Health Aides.** 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, 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 42 CFR § 484.80(h)(1), but virtual supervision is encouraged during the period of the waiver.

- **Reporting.** CMS is providing relief to HHAs on the timeframes related to OASIS transmission through the following 1) extending the 5-day completion requirement for the comprehensive assessment to 30 days; and 2) waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE. We are now allowing 30 days for the completion of the comprehensive assessment. HHAs must submit OASIS data prior to submitting their final claim in order to receive Medicare payment.

- **Clinical Records.** In accordance with section 1135(b)(5) of the Social Security Act, CMS is extending the deadline for completion of the requirement at 42 CFR § 484.110(e), which requires HHAs to provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient). Specifically, CMS will allow HHAs ten business days to provide a patient's clinical record, instead of four.

- **Training and Assessment of Aides.** CMS is waiving the requirement at 42 CFR § 418.76(h)(2) for Hospice and 42 CFR § 484.80(h)(1)(iii) for HHAs, which require a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist) to make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency. CMS is postponing completion of these visits. All postponed onsite assessments must be completed by these professionals no later than 60 days after the expiration of the PHE.

- **Hospice Aide Competency Testing Allow Use of Pseudo Patients.** 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 patient health and safety during the (PHE).

- **Hospice Aide In-Service Training Waiver.** CMS is waiving the requirement at 42 CFR § 418.76(d) for hospices to assure that each hospice aide receives 12 hours of in-service training in a 12- month period.

- **Comprehensive Assessments.** CMS is waiving certain requirements at 42 CFR § 418.54 related to updating comprehensive assessments of patients. This waiver applies the timeframes for updates to the comprehensive assessment found at 42 CFR § 418.54(d). Hospices must continue to complete the required assessments and updates; however, the timeframes for updating the assessment may be extended from 15 to 21 days.