Supporting Statement Part A
Submissions of 1135 Waiver Request Automated Process (CMS-10752)

A. Background

This is a revision of an information collection request approved under Office of Management and Budget (OMB) control number of 0938-1384 with an expiration date of August 31, 2026. This package will be classified as a Revision rather than an "extension." Additionally, the Acute Hospital Care at Home (AHCAH) program will no longer be included in this package.

Waivers under Section 1135 of the Social Security Act (the Act) and certain flexibilities allow the CMS to relax certain requirements, known as the Conditions of Participation (CoPs) or Conditions of Coverage to promote the health and safety of beneficiaries. Under Section 1135 of the Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods. These waivers ensure that healthcare entities/caregivers who provide such services in good faith can be reimbursed and exempted from sanctions.

During emergencies, CMS must be able to apply program waivers and flexibilities under section 1135 of the Social Security Act, in a timely manner to respond quickly to unfolding events. In a disaster or emergency, waivers and flexibilities assist health care providers/suppliers in providing timely healthcare and services to people who have been affected and enables states, Federal districts, and U.S. territories to ensure Medicare and/or Medicaid beneficiaries have continued access to care. During disasters and emergencies, it is not uncommon to evacuate patients in health care facilities to other provider settings or across state lines, especially, during hurricane, wildfire, and tornado events. CMS must collect relevant information for which a provider is requesting a waiver or flexibility to make proper decisions about approving or denying such requests. Collection of this data aids in the prevention of gaps in access to care and services before, during, and after an emergency. CMS must also respond to inquiries related to a Public Health Emergency (PHE) from providers. CMS is not collecting information from these inquiries; we are merely responding to them.

The collection of the information surrounding 1135 Waiver requests/inquiries is based on a case-by-case basis and not regularly scheduled (e.g., quarterly, annually, by all providers/suppliers). The collection of information only occurs when the healthcare entity, impacted by an emergency, is requesting waivers/flexibilities under Section 1135 of the Act or inquiring about PHEs. The collection of information is also dependent on provider types; therefore, it is not a collection for all Medicare-participating facilities.

In 2021, we implemented a streamlined, automated process to standardize the 1135 waiver requests and inquiries submitted based on lessons learned during the COVID-19 PHE.

Furthermore, the normal operations of a healthcare provider are disrupted by emergencies or disasters occasionally. When this occurs, State Survey Agencies (SA) deliver a

provider/beneficiary tracking report regarding the current status of all affected healthcare providers and their beneficiaries. This report includes demographic information about the beneficiary status, provider, their operational status, anticipated needs and planned resumption of normal operations. This information is provided whether or not a PHE has been declared.

We are enhancing this information collection to better support emergency response by capturing the emergency date, simplifying ongoing status updates for stakeholders, and providing a more comprehensive view of cybersecurity incidents through expanded reporting on patient and operational impacts. This automated process will continue to consist of a public facing web form as well as a process for SAs/Providers to submit data using extracts (CSV or Excel) on emergent events impacting Health Care Facilities via automated mail handler system. Both processes (public facing web form and extracts via an automated mail handler system) are known as the Health Care Facility (HCF) Operational Status.

B. Justification

1. Need and Legal Basis

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Health and Human Services (HHS) Secretary declares a PHE under Section 319 of the Public Health Service Act, the Secretary is authorized to temporarily waive or modify certain Medicare, Medicaid, CHIP and Health Insurance Portability and Accountability Act (HIPAA) requirements. Waiving such requirements ensures that sufficient health care services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods, and to reimburse and exempt from sanctions healthcare entities/caregivers who provide such services in good faith.

The statutory authorities that allow for the implementation of waivers and flexibilities are Section 1812(f) of the Social Security Act, Section 1135 of the Social Security Act, and Section 319 of the Public Health Service Act. Prior to the COVID-19 PHE, CMS Locations (formerly known as Regional Offices) executed manual processes using Excel spreadsheets, Access databases, Word documents and Outlook email to monitor, track, respond and report on the volume and specifics of requests and inquiries. However, the COVID-19 PHE presented a new challenge as Medicare and Medicaid providers/suppliers were impacted on a 24-hour basis throughout the duration of the PHE. CMS acknowledges that the streamlined process implemented since 2021 continues to assist in all PHEs (e.g., hurricanes, wildfires, tornados and other emergencies).

The magnitude of 1135 requests and PHE-related inquiries by CMS-participating providers and suppliers is ongoing to date. This long-term information technology (IT) solution supports incoming requests/inquiries, maintains a repository for tracking purposes, improves data quality and automates the process, where possible, to improve program efficiencies and CMS/HHS responsiveness.

During disasters and emergencies, it is not uncommon to evacuate patients/residents/clients in health care facilities to other provider settings or across state lines, especially during hurricane, wildfire, and tornado events. When healthcare providers cannot operate normally, CMS must understand how and where they are operating. Providers coordinate with their SAs to provide this information to CMS, and each State determines the format and media in which the information is provided. This results in the need for CMS to gather and organize the information, standardize the format and media for efficient planning and coordination across HHS. Standardizing the reporting of operational status information improves efficiency and prevents gaps in access to care as well as accelerates CMS' response to the identified needs of beneficiaries and providers.

2. Information Users

This information is used by CMS to receive, triage, respond to and report on requests and/or inquiries for Medicare, Medicaid, and CHIP beneficiaries. In addition, this information is used to make decisions about approving or denying waiver and flexibility requests. The information may also be used to identify trends that inform CMS Conditions for Coverage or Conditions for Participation policies during PHEs, when declared by the President and the HHS Secretary.

Operational status information will be used to assist providers in delivering critical care to beneficiaries during emergencies.

3. Use of Information Technology

This information is collected electronically using public facing web forms. This process includes requests from Medicare-participating provider/suppliers, associations, corporations, or State/local governments submitting on behalf of a provider/supplier.

CMS created a public facing web form to support nationwide submission of 1135 waiver requests and inquiries by collecting required information from impacted Medicare/Medicaid providers, Healthcare Associations, Governors, and States. Thus, creation of this standard and automated 1135 process by utilizing a publicly accessible web form enabled a standardized, user-friendly submission by requesters and more efficient processing for all impacted components within CMS.

CMS created a second public facing web form to support nationwide reporting about the operational status of healthcare providers and their beneficiaries impacted by emergencies and disasters. CMS enhanced this process by utilizing the publicly accessible web form as well as an alternate process to obtain this data using extracts (single event or bulk) sent from States/Providers/Suppliers impacted by the emergent event via an automated mail handler system. Standardized collection of this data helps CMS to prevent gaps in access to care and services before, during and after an emergency/disaster. Enhancements include: (1) the addition of a field to capture the date of the emergency, (2) modifications that allow stakeholders to provide status updates throughout various phases of an emergency without the need to complete all required fields for each submission, and (3) improvements to the

cybersecurity section that enable stakeholders to report the extent of negative impacts from cyberattacks on both patients and operational functions. Together, these represent a shift from **rigid, comprehensive reporting requirements** to a more **adaptive, stakeholder-friendly approach** that recognizes the dynamic nature of emergency situations. These enhancements to this Health Care Facility (HCF) Operational Status report create a **win-win scenario**: better protection for vulnerable Medicare and Medicaid beneficiaries through improved emergency intelligence, while simultaneously reducing administrative friction for the states and healthcare providers who serve them during crisis situations.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

These requirements do affect small businesses; however, the information collection is only collected if requested during an emergency event and if an 1135 Waiver request or PHE-related inquiry is submitted. Additionally, operational status information is only necessary if a healthcare provider is or anticipates being unable to function normally. These paperwork requirements are minimal and are necessary to meet the documentation and disclosure requirements of the law.

An automated process minimizes the burden on small businesses by:

- Standardizing the process so providers don't have to design their own form
- Decreasing the amount of time required by providers to submit their requests, inquiries, or operational status to CMS
- Eliminating fragmented responses by CMS
- Improving the timeliness of responses to healthcare entities
- Ensuring nationwide consistency among impacted components
- Reducing the need for CMS to request additional information, so providers do not have to resubmit information
- 100% of this information will be used electronically

6. Less Frequent Collection

There is no schedule of collection; these waiver requests and inquiries are submitted as needed when there is a natural or man-made emergency/disaster that impacts access to care for Medicare/Medicaid/CHIP beneficiaries. The HCF status is reported only when a facility is not in or anticipates not being in a normal operational status.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on March 31, 2026 (91 FR 16002).

There was one public comment received. The commenter recommended that CMS align emergency response activities, including Section 1135 waiver processes and Health Care Facility (HCF) operational status reporting, with modern interoperability infrastructure, including FHIR-based APIs and the International Patient Summary U.S. Realm (IPS-US), to support information exchange across state lines.

CMS appreciates the comment and recognizes the importance of advancing healthcare interoperability and standards-based information exchange. However, the purpose of this information collection is to support rapid situational awareness during disasters and emergency events by collecting operational status information from affected healthcare providers and suppliers. The information collected includes facility operational status, beneficiary impact counts, evacuation and relocation information, infrastructure impacts, and other emergency-related data necessary to support emergency response activities. This collection does not currently collect patient-level clinical summaries.

CMS believes the current standardized electronic reporting approach appropriately supports the operational needs of emergency response by prioritizing speed, simplicity, accessibility, and reduced reporting burden for all provider and supplier types, including small and rural facilities that may have varying levels of health information technology capabilities. As Federal interoperability initiatives continue to evolve, CMS will evaluate opportunities to enhance emergency response reporting processes, as appropriate, while maintaining the primary objective of timely and efficient collection of critical operational information during disasters and emergencies.

No changes were made to the information collection as a result of this comment.

The 30-day Federal Register notice published on June 18, 2026 (91 FR 36840).

9. Payments/Gifts to Respondents

There are no payments or gifts to respondents.

10. Confidentiality

Personally identifiable information, including social security numbers (SSN), is not being collected on these web forms. Information is being collected electronically in the ServiceNow system and is covered by that system's Privacy Impact Assessment (PIA) with an approval date of November 21, 2024. Information is stored electronically in the ServiceNow system. Personal Identifiable Information/Personal Health Information (PII/PHI), if submitted, will be identified by a CMS triage agent and will follow the current CMS processes and procedures for reporting PII incidents. This includes opening a security incident, investigation, and remediation. Data collected via the automated process is retained for seven years, as approved by the National Archives and Records Administration Records Schedule DM-0440-

2015-0008. The data resides in the ServiceNow system. The confidentiality, integrity, and availability of information being processed is protected by a wide variety of organizational, process, and technical controls to ensure professionalism and trustworthiness. Such safeguards include communication protocols, software to facilitate incident analysis and mitigation practices as well as other incident analysis resources.

11. Sensitive Questions

There are no questions of a sensitive nature.

12. Burden Estimates (Hours & Wages)

Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' 2024 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Table 1: National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Blended Occupations – Waiver Requests	See Table 2 below	$69.45	$69.45	$138.90
Blended Occupations - Inquiries	See Table 3 below	$67.02	$67.02	$134.04
Blended Occupations – Operational Status	See Table 4 below	$45.65	$45.65	$91.30

As indicated, we adjusted our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

From calendar year 2024 to date, CMS has received over 1,482 Waiver Requests (1,368

Waiver Requests from non-State Medicaid Agencies (SMAs) and 114 Waiver Requests from SMAs). It takes 15 minutes per entity to submit the waiver request to CMS. It also takes 15 minutes to consult with the provider/supplier's administrator, Chief Executive Officer (CEO) or another top executive. This would be a total of 30 minutes. The total annual burden hours would be 741 (0.5 hour X 1,482 waivers).

The total annual cost would be $102,924.90 (741 hours X $138.90)

Table 2: Blended Occupations	**BLS Occupation Code**	**Mean hourly wage**	**Fringe Benefits**
Nursing Home Administrator	43-1011	$34.40	$34.40
General Physician	29-1216	$130.92	$130.92
Hospital Administrator	11*9111	$68.15	$68.15
CEO	11-1011	$126.41	$126.41
Rehabilitation Therapist	21-1015	$24.64	$24.64
Administrator	43-1011	$34.40	$34.40
State Agency Director	11-1000	$67.24	$67.24
Total Mean Hourly Wage		$486.16	$486.16
Average Hourly Wage		**$69.45**	**$69.45**

$69.45	average hourly wage
$69.45 +	increased by a factor of 100 percent
= $138.90	Average Hourly wage used in PRA package
Number of unique respondents:	345

From calendar year 2024 to date, CMS has received about 144 individual Inquiries. We anticipate that it would generally take 30 minutes per entity to submit an inquiry to CMS. The total annual burden hours would be 72 (0.5 hour X 144 inquiries).

The total annual cost would be $9,650.88 (72 hours X 134.04).

Table 3: Blended Occupations	**BLS Occupation Code**	**Mean hourly wage**	**Fringe Benefits**
Nursing Home Administrator	43-1011	$34.40	$34.40
General Physician	29-1216	$130.92	$130.92
Hospital Administrator	11*9111	$68.15	$68.15

Administrator	43-1011	$34.40	$34.40
State Agency Director	11-1000	$67.24	$67.24
Total Mean Hourly Wage		$335.11	$335.11
Average Hourly Wage		**$67.02**	**$67.02**

* We used data from the U.S. Bureau of Labor Statistics' 2022 National Occupational Employment and Wage Estimates for all salary estimates.

$67.02	average hourly wage
$67.02 +	increased by a factor of 100 percent
= $134.04	Average Hourly wage used in PRA package
Number of unique respondents:	91

From calendar year 2024, CMS received about 3,203 Health Care Facility (HCF) operational status reports. We estimate that it would take about 60 minutes to submit this information to CMS. The total burden annual hours would be 3,203 (1 hour x 3,203 reports).

The total annual cost would be $292,433.90 (3,203 x $91.30).

Table 4: Blended Occupations	**BLS Occupation Code**	**Mean hourly wage**	**Fringe Benefits**
Nursing Home Administrator	43-1011	$34.40	$34.40
Hospital Administrator	11*9111	$68.15	$68.15
Administrator	43-1011	$34.40	$34.40
Total Mean Hourly Wage		$136.95	$136.95
Average Hourly Wage		**$45.65**	**$45.65**

$**45.65**	average hourly wage
$**45.65** +	increased by a factor of 100 percent
= $91.30	Average Hourly wage used in PRA package
Number of unique respondents:	3,203

We estimate the total annual hours to be 4,016 and cost of all data types to be $405,009.68.

Data Type	2025 Responses	Annual Total	Estimated Annual Cost

		Burden Hours requested	
1135 Waiver Requests	1,482	741	$102,924.90
Inquiries	144	72	$9,650.88
Health Care Facility (HCF) Operational Status	3,203	3,203	$292,433.90
Totals	4,829	4,016	$405,009.68

The total annual burden hours are 4,016 (741 [1135 waivers] + 72 [inquiries] + 3,203 [HCF].

13. Capital Costs

Although there are no capital costs associated with this collection, these public-facing web forms provide an automated mechanism for submitting waiver requests, inquiries and operational status.

14. Cost to Federal Government

Implementation of the public facing web form required a contract with an application development organization and the purchase of user licenses for CMS users. The total annual cost is $742,034.13.

	Development Contract	**User Licenses**
Annual Cost	$679,945.20	$62,088.93
Total Annual Cost	$742,034.13	

The CMS Locations are responsible for responding to 1135 waiver requests and inquiries. We estimate that it would take 30 minutes of time by a CMS Location reviewer to review and determine if the 1135 waiver request and/or inquiry has sufficient information to make a determination.

We estimate that the cost associated with reviewing each web form by the CMS Location would be $31.53. We note, these are not reoccurring submissions and are only submitted during emergency events.

These costs were calculated using the annual salary of a GS-13, Step 5 reviewer in the Pennsylvania CMS Location, which is $131,607, and which equates to an average hourly

salary of $63.06. It takes the CMS Location 30 min to review at a rate of $31.53 (.5 x $63.06 per hour). The total annual cost is $152,258.37 ($31.53 x 4,829 forms).

The total annual cost to the government is $894,293

15. Changes to Burden

The annual burden hours have decreased from 8,324 to 4,016 due to the decreased number of waiver submissions. The wage rates have been updated to year 2024. The annual cost has changed from $502,536.25to $405,009.68. NOTE: The Acute Hospital Care at Home (AHCAH) is no longer a part of this package. It is now in a separate package.

16. Publication/Tabulation Dates

There will be no publication.

17. Expiration Date

CMS will display the expiration date on the collection instrument.

18. Certification Statement

There are no exceptions.