



CMS Issues COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

On April 10, the Centers for Medicare and Medicaid Services (CMS) temporarily suspended a number of rules so that hospitals, clinics, and other healthcare facilities can boost their frontline medical staff as they fight to save lives during the COVID-19 pandemic.

These changes affect doctors, nurses, and other clinicians nationwide, and focus on reducing supervision and certification requirements so that practitioners can be hired quickly and perform work to the fullest extent of their licenses. To see the full fact sheet, click [here](#), or continue reading for a summary of provisions impacting ASH members.

Provider Enrollment

CMS has established toll-free hotlines at each of the Medicare Administrative Contractors (MACs) to allow physicians, non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges.

Click [here](#) to locate your designated MAC and a list of hotline numbers.

Physician Services

CMS is waiving requirements stating 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.

Practitioner 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. 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 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.

Verbal Orders

CMS is waiving requirements to provide additional flexibility related to verbal orders where read-back verification is required, but authentication may occur later than 48 hours. Specifically, the following requirements are waived:

- If verbal orders are used for the use of drugs and biologicals (except immunizations), they are to be used infrequently.

- All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders.
- Although the regulation requires that medication administration be based on a written, signed order, this does not preclude the CAH from using verbal orders. A practitioner responsible for the care of the patient must authenticate the order in writing as soon as possible after the fact.

Discharge Planning for Hospitals and Critical Access Hospitals (CAHs)

CMS is waiving the requirement to provide detailed information regarding discharge planning, described below:

- The hospital, psychiatric hospital, and CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency (HHA), skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures.
- The hospital must ensure that the post-acute care data on quality measures and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
- CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care.

CMS is waiving all the requirements 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. CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care. CMS is waiving the more detailed requirement that hospitals ensure those patients discharged home and referred for HHA services, or transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, must:

- (1) Include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient.
- (2) Inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services.
- (3) Identify in the discharge plan any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.