Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

This CMS cross-cutting initiative focused on evaluating CMS-issued PHE waivers and flexibilities to prepare the health care system for operation after the PHE. This review happened in three concurrent phases:

1. CMS assessed the need for continuing certain waivers based on the current phase of the PHE. Since the beginning of the PHE, CMS has both added and terminated flexibilities and waivers as needed. In doing so, CMS considered the impacts on communities — including underserved communities — and the potential barriers and opportunities that the flexibilities may address.

2. CMS assessed which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing health care.

3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is holistically prepared for addressing future emergencies.

As CMS identified barriers and opportunities for improvement, the needs of each person and community served were considered and assessed with a health equity lens to ensure our analysis, stakeholder engagement, and policy decisions account for health equity impacts on members of underserved communities and health care professionals disproportionately serving these communities.

Please note: This fact sheet focuses on Medicare and Medicaid flexibilities only.

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with comment period (IFC) announcing that Medicare Part B would establish coding and payment rates for COVID-19 vaccines and their administration as preventive vaccines, without cost-sharing, as soon as the

Food and Drug Administration (FDA) authorized or approved the product through an Emergency Use Authorization (EUA) or Biologics License Application (BLA). The IFC also implemented provisions of the CARES Act to ensure swift coverage of COVID-19 vaccines by private health insurance plans participating in the Health Insurance Marketplace, without cost sharing, from both in- and out-of-network providers, during the course of the public health emergency (PHE).

For patients in a Part A-covered SNF stay, CMS exercised "enforcement discretion," which allowed Medicare-enrolled immunizers, including but not limited to pharmacies working with the United States, to bill directly and receive direct payment from the Medicare program for vaccinating Medicare SNF residents.

Payment After the End of the PHE

CMS will continue to pay approximately $40 per dose for administering COVID-19 vaccines in most outpatient settings for Medicare beneficiaries through the end of the calendar year in which the Secretary ends the EUA declaration for drugs and biologicals with respect to COVID-19.

Effective January 1 of the year following the year in which the EUA declaration ends, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for administering other Part B preventive vaccines, that is, approximately $30 per dose.

The enforcement discretion described above associated with vaccinating Medicare SNF residents will end on June 30th, 2023, meaning that immunizers will no longer be able to bill Medicare directly for vaccines furnished to patients for a Medicare Part A-covered SNF stay. Beginning on July 1, typical SNF consolidated billing regulations will be in place, which require SNFs to bill for all services furnished to patients in a Medicare-covered SNF stay, including vaccines.

Additional Payment for Administering the Vaccine in the Patient's Home

In calendar year 2023, CMS will pay approximately $36 in addition to the standard administration amount (approximately $40) per dose to administer COVID-19 vaccines in the home for certain Medicare patients. For vaccines requiring multiple doses, this payment applies for each dose in the series, including any additional or booster doses. We also geographically adjust the additional amount and administration rate based on where you administer the vaccine. Starting January 1, 2023, we'll also annually update the additional in-home payment rate for administering the COVID-19 vaccine to reflect changes in costs related to administering preventive vaccines.

Additional Payment for Administering the Vaccine in the Patient's Home After the End of the PHE

We'll continue to pay a total payment of approximately $76 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through calendar year 2023. The additional payment is not affected by the end of the PHE.

More information: COVID-19 vaccine toolkits

- Providers
  - Payment
  - Billing
  - Coding
- Health & Drug Plans
- State Medicaid programs

COVID-19 Monoclonal Antibodies

There are currently no COVID-19 monoclonal antibodies approved or authorized for use against the dominant strains of COVID-19 in the United States.

The FDA issued emergency use authorizations (EUA) for monoclonal antibody therapies used for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. The FDA also issued an EUA for a monoclonal antibody product used as a pre-exposure prophylaxis of COVID-19 in adults and pediatric patients with certain conditions.

During the EUA declaration for drugs and biologicals with respect to COVID-19, CMS covers and pays for these infusions or injections the same way it covers and pays for COVID-19 vaccines when furnished consistent with the EUA. There's also no beneficiary cost sharing and no deductible for COVID-19 monoclonal antibody products when providers administer them. In the event these products become approved or authorized for use, they will continue to be covered and paid under the Medicare Part B preventive vaccine benefit until the end of the calendar year in which the Secretary ends the EUA declaration. This coverage and payment will continue even if the PHE ends.

CMS doesn't pay for the COVID-19 monoclonal antibody product when a health care setting has received it for free. If a health care setting purchased the product from the manufacturer, Medicare pays the reasonable cost or 95% of the average wholesale price.

More information: COVID-19 Monoclonal Antibodies

Payment After the End of the PHE

Effective January 1 of the year in which the Secretary ends the EUA declaration for drugs and biologicals with respect to COVID-19, CMS will pay for monoclonal antibodies used for the treatment or for post-exposure prophylaxis of COVID-19:

- As we pay for biological products under Section 1847A of the Social Security Act.

- Through the applicable payment system, using the appropriate coding and payment rates, similar to the way we pay for administering other complex biological products.

Monoclonal antibodies that are used for pre-exposure prophylaxis prevention of COVID-19 will continue to be paid under the Part B preventive vaccine benefit if they meet applicable coverage requirements.

COVID-19 VEKLURY™ (remdesivir)

As of April 25, 2022, the FDA updated the approval of VEKLURY™ (remdesivir) as approved for the treatment of COVID-19. The federal government didn't purchase a supply of remdesivir. Medicare Part B provides payment for the drug and its administration under the applicable Medicare Part B payment policy when a facility or practitioner provides it in the outpatient setting, according to the FDA approval. In most cases, the Medicare patient's yearly Part B deductible and 20% co-insurance apply. Beginning on January 1, 2024, for beneficiaries in a Medicare Part A-covered SNF stay, payment for remdesivir would be subject to SNF consolidated billing and would not be separately billable to Part B.

Medicare Coverage for Over-the-Counter COVID-19 Tests. On April 4, 2022, Medicare implemented a demonstration program to allow people with Medicare to receive up to eight tests per calendar month at no cost. This is the first time that Medicare has covered an over-the-counter, self-administered, test. This new initiative enables people with Medicare Part B, including those enrolled in a Medicare Advantage plan, to receive tests at no cost from providers and suppliers who are eligible to participate. Pharmacies and other health care providers interested in participating in this initiative can get more information here: https://www.cms.gov/COVIDOTCtestsProvider. **This program will end at the end of the COVID-19 public health emergency.**

Reducing Administrative Burden

- *Physical Environment*: Provided that the state has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS waived requirements under 42 CFR §483.90 to allow for a non-SNF/NF building to be temporarily certified as, and available for use by, a SNF in the event there are needs for isolation processes for COVID-19 positive residents, which may not be feasible in the existing SNF structure, to ensure care and services during treatment for COVID-19 is available while protecting other vulnerable adults. CMS believed that this flexibility provided another measure that relinquished inpatient care beds at hospitals for the most acute patients, while providing beds for those still in need of care. CMS waived certain conditions of participation and certification requirements for opening a SNF/NF if the state determines there is a need to quickly stand up a temporary COVID-19 isolation and treatment location. To assist with isolation needs, CMS also temporarily allowed 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, comfortable, and other applicable requirements for participation are met. This flexibility was allowed so long as it was not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department. ***(This waiver terminated on 06-06-2022 per QSO-22-15-NH&NLTC&LSC)***

- *Three-Day Prior Hospitalization*: Using the statutory flexibility under Section 1812(f) of the Social Security Act, CMS temporarily waived the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay. This waiver provides temporary emergency coverage of SNF services without a qualifying hospital stay. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes a one-time renewed SNF coverage without first having to start and complete a 60-day "wellness period" (that is, the 60-day period of non-inpatient status that is normally required in order to end the current benefit period and renew SNF benefits). This waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the 60-day "wellness period" that would have occurred under normal circumstances. By contrast, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the Section 1812(f) waiver, as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day "wellness period." **This waiver will terminate at the end of the COVID-19 PHE.**

- *Reporting Minimum Data Set*: CMS waived 42 CFR §483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission. This waiver terminated and **reporting of Minimum Data Set was reinstated May 10, 2021 QSO-21-17-NH.**

- *Staffing Data Submission*: CMS waived 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. This waiver terminated and **submission of staffing data through the Payroll Based Journal system was reinstated on June 25, 2020.**

- *Waive Pre-Admission Screening and Annual Resident Review (PASRR):* CMS has been allowing states and nursing homes to suspend these assessments for new residents for 30 days. After 30 days, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should receive the assessment as soon as resources become available. **CMS will end this waiver at the conclusion of the COVID-19 PHE.**

- *Resident Groups:* CMS waived the requirements at §483.10(f)(5) to allow for residents to have the right to participate in-person in resident groups. This waiver only permitted the facility to restrict having in-person meetings during the national emergency given the recommendations of social distancing and limiting gatherings of more than ten people. Refraining from in-person gatherings will help prevent the spread of COVID-19. (**This waiver was terminated on 05/07/2022 per QSO-22-15-NH&NLTC&LSC.0**)

- *Quality Assurance and Performance Improvement (QAPI).* CMS modified certain requirements in 42 CFR §483.75, which required long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS modified §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This waiver helped to ensure facilities focused on aspects of care delivery most closely associated with COVID-19 during the PHE. **(This waiver was terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC)**

- *In-Service Training*: CMS modified the nurse aide training requirements at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually. In accordance with section 1135(b)(5) of the Act, CMS postponed the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. (**This waiver was terminated on 06-06-2022 per QSO-22-15-NH&NLTC&LSC).**

- *Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities.* CMS waived the discharge planning requirement in §483.21(c)(1)(viii), which

required LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use. This temporary waiver provided facilities the ability to expedite discharge and movement of residents among care settings. CMS maintained all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident were identified and resulted in the development of a discharge plan for each resident; and involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan to address the resident's goals of care and treatment preferences. **(This waiver was terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC)**

- *Clinical Records*. Pursuant to section 1135(b)(5) of the Act, CMS modified the requirement at 42 CFR §483.10(g)(2)(ii), which required long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident). Specifically, CMS modified the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days. **(This waiver was terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC)**

- *Provider Enrollment*: During the PHE, CMS has established toll-free hotlines for physicians, non-physician practitioners, and Part A certified providers and suppliers who have established isolation facilities to enroll and receive temporary Medicare billing privileges. **When the PHE ends, the hotlines will be shut down.** Additionally, CMS has provided the following flexibilities for provider enrollment:

  - *Screening requirements:*
    - Site Visits: CMS waived provider enrollment site visits for moderate and high-risk providers/suppliers. ***(This waiver terminated on 07-06-2020 and CMS, in accordance with 42 CFR §§ 424.517 and 424.518, resumed all provider enrollment site visits.)***

    - *Fingerprint-based criminal background checks:* CMS waived the requirement for fingerprint-based criminal background checks for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers (e.g., newly-enrolling Home Health Agencies, DMEPOS suppliers, Medicare Diabetes Prevention Programs, Opioid Treatment Programs). ***(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 CFR § 424.518, resumed requesting fingerprints for all newly enrolling high-risk providers and suppliers.)***

  - *Application Fees:* CMS waived the collection of application fees for institutional providers who are initially enrolling, revalidating, or adding a new practice location.

(This waiver terminated on 10/31/2021 and CMS, in accordance with 42 CFR § 424.514, resumed collecting application fees.)

- *Revalidation:* CMS postponed all revalidation actions. This did not prevent a provider who wants to submit a revalidation application from doing so; MACs processed revalidation applications. ***(This waiver terminated on 10/31/2021 and CMS resumed a phased-in approach to revalidation activities; revalidation letters began being mailed again in October 2021 with due dates in early 2022.)***

- *Expedited Enrollment:* CMS expedited any pending or new applications from providers and suppliers, including physicians and non-physician practitioners received on or after March 1, 2020. **When the PHE ends, CMS will resume normal application processing times.**

- *Opt-Out Enrollment:* CMS allowed practitioners to cancel their opt-out status early and enroll in Medicare to provide care to more patients. CMS also allowed MACs to accept opt-out cancellation requests via email, fax, or phone call to the hotline. CMS allowed a provider to submit an application (an 855-I or 855-R for example) to cancel their opt-out. Providers were not required to submit a written notification to cancel their opt-out status. **When the PHE ends, this waiver will terminate and opted-out practitioners will not be able to cancel their opt-out statuses earlier than the applicable regulation at 42 CFR 405.445 allows for.**

- *Reporting Home Address:* During the PHE, CMS allowed 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. **When the PHE ends, the waiver will continue through December 31, 2023.**

- *State Licensure:* During the PHE, CMS allowed licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment. **CMS has determined that, when the PHE ends, CMS regulations will continue to allow for a total deferral to state law.** Thus, there is no CMS-based requirement that a provider must be licensed in its state of enrollment.

Establish data reporting vehicle critical to addressing the pandemic

- *Required Facility Reporting:* Under §483.80(g), long-term care facilities are required to report COVID-19 cases in their facility to the CDC National Health Safety Network (NHSN) on a weekly basis. CDC and CMS will use information collected through the new NHSN Long-term Care COVID-19 Module to strengthen COVID-19 surveillance locally and nationally; monitor trends in infection rates; and help local, state, and federal health authorities get help to nursing homes faster. Nursing home reporting to the CDC is a critical component of the national COVID-19 surveillance system and to efforts to

reopen America. The information will also be posted online for the public to be aware of how the COVID-19 pandemic is affecting nursing homes. In COVID-19 Public Health Emergency Interim Final Rule #3 (CMS-3401-IFC), CMS is codifying enforcement actions for facilities' noncompliance with this requirement. Failure to report will result in the imposition of a civil money penalty for each occurrence of non-reporting as follows: A civil money penalty of $1,000 for the first occurrence, followed by $500 added to the previously imposed civil money penalty for each subsequent occurrence, not to exceed the maximum amount set forth in § 488.408(d)(1)(iii).

Facilities are also required to notify residents, their representatives, and families of residents in facilities of the status of COVID-19 in the facility, which includes any new cases of COVID-19 as they are identified. This action supports CMS' commitment to transparency so that individuals know important information about their environment, or the environment of a loved one. **The 2022 CY Home Health PPS Rule extended this mandatory COVID-19 reporting requirement beyond the current COVID-19 PHE until December 31, 2024**.

Payment

- *COVID-19 Accelerated and Advance Payments (CAAP)*: For the most up to date information related to the CAAP Program please visit https://www.cms.gov/medicare/covid-19-accelerated-and-advance-payments

Medicare appeals in Traditional Medicare, Medicare Advantage (MA) and Part D

- During the PHE, CMS has been allowing Medicare Administrative Contractors (MACs) and Qualified Independent Contractor (QICs) in the FFS program (42 CFR 405.942 and 42 CFR 405.962) and MA and Part D plans, as well as the Part C and Part D Independent Review Entity (IREs) (42 CFR 422.582 and 42 CFR 423.582) to allow extensions to file an appeal. Specifically, 42 CFR 422.582(c) and 42 CFR 423.582(c) allow a Part C or Part D plan to extend the timeframe for filing a request if there is good cause for the late filing. In addition, the Part D IRE may find good cause for late filing of a request for reconsideration. **When the COVID-19 PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements**.

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966), and the Part C and Part D IREs, to waive requirements for timeliness for requests for additional information to adjudicate appeals**.** In addition, under applicable regulations, MA plans may extend the timeframe to adjudicate organization determinations, and reconsiderations for medical items and services (but not Part B drugs), by up to 14 calendar days if: the enrollee requests the extension; the extension is justified and in the enrollee's interest, due to the need for additional medical evidence from a noncontract provider that may change an MA organization's

decision to deny an item or service; or, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest (42 CFR 422.568(b)(1)(i), 42 CFR 422.572(b)(1) and 42 CFR 422.590(f)(1)). When the COVID-19 PHE ends, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements.

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405.910) and MA and Part D plans, as well as the Part C and Part D IREs, to process an appeal even with incomplete Appointment of Representation forms (see 42 CFR 422.561 and 42 CFR 423.560 for definitions of "representative"). However, any communication was sent only to the beneficiary. When the COVID-19 PHE ends, this flexibility will continue to apply, consistent with existing guidance for the MACs and QIC in the FFS program. For MA and Part D plans, as well as the Part C and Part D IREs, this flexibility will no longer apply. The MA and Part D plans, as well as the Part C and D IREs, must process the appeals based on regulatory requirements (42 CFR 422.582(f)-(g), 42 CFR 423.582(e)-(f), 42 CFR 422.592(d)-(e), and 42 CFR 423.600(g)-(h)).

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to process requests for appeal that don't meet the required elements, but instead use information that is available (42 CFR 422.562 and 42 CFR 423.562). **When the COVID-19 PHE ends, requests for appeals must meet the existing regulatory requirements.**

- During the PHE, CMS has been allowing MACs and QICs in the FFS program (42 CFR 405. 950 and 42 CFR 405.966) and MA and Part D plans, as well as the Part C and Part D IREs, to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied. **When the PHE ends, these flexibilities may only be provided consistent with existing regulatory authority.**

- *Cost Reporting*. Providers that continue to experience the impacts of the PHE and require additional time to file their cost report may submit a request to their MAC in accordance with our regulation at 42 CFR 413.24 (f)(2)(ii). The MAC has the authority to grant up to a 60-day extension of the due date for filing a cost report if the provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as the PHE.

Temporary Expansion Sites

- *Transfers of COVID -19 Patients*: A long term care (LTC) facility can temporarily transfer its COVID-19 positive resident(s) to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements." The transferring LTC facility need not issue a formal discharge in this situation, as it is still considered the provider and should bill Medicare normally for each day of care. The

transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period. This is consistent with recent CDC guidance, and helps residents with COVID-19 by placing them into facilities that are prepared to care for them. It also helps residents without COVID-19 by placing them in facilities without other COVID-19 residents, thus helping to protect them from being infected.

If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The SNF should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf) to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.

- *Resident Transfer and Discharge:* CMS waived requirements in 42 CFR 483.10(c)(5); 483.15(c)(3) (which was Terminated on 05/10/2021 per QSO-21-17); and (d), (which was also terminated on 05/10/2021 per QSO-21-17), with some exceptions noted below, to allow a long-term care facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes:

  1. Transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents.

  2. Transferring residents without symptoms of a respiratory infection, or confirmed to not have COVID-19, to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to prevent them from acquiring COVID-19, as well as providing treatment or therapy for other conditions as required by the resident's plan of care.

  3. Transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days.

     Exceptions:
     - These requirements are **only** waived in cases where the transferring facility receives confirmation that the receiving facility agrees to accept the resident tobe transferred or discharged. Confirmation may be in writing or verbal. If

verbal, the transferring facility needs to document the date, time, and person that the receiving facility communicated agreement.

- In § 483.10, we are only waiving the requirement, under § 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to § 483.10 continue to apply. Similarly, in § 483.15, we only waived the requirement, under § 483.15(c)(3), (c)(4)(ii) (which was terminated on 05/10/2021 per QSO-21-17), (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable.

- In § 483.21, CMS only waived the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above. Receiving facilities should complete the required care plans as soon as practicable, and we expected receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents they apply to. **(This waiver was terminated on 05/10/2021 per QSO-21-17).**

- These requirements are also waived when the transferring residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements," while remaining consistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department. In these cases, the transferring LTC facility need not issue a formal discharge, as it is still considered the resident's provider and should bill Medicare normally for each day of care. The transferring LTC facility is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period.

- If the LTC facility does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The LTC facility should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf) to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges.

We remind LTC facilities that they are responsible for ensuring that any transfers (either within a facility, or to another facility) are conducted in a safe and orderly manner, and that each resident's health and safety is protected. We also remind states that under 42 CFR 488.426(a)(1), in an emergency, the state has the authority to transfer Medicaid and Medicare residents to another facility.

- *Resident Roommates and Grouping:* CMS has been waiving the requirements in 42 CFR 483.10(e)(5), (6), **(note that Section (6) was terminated on 05/10/2021 per QSO-21-17)**, and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with 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.

- *Inspection, Testing & Maintenance (ITM) under the Physical Environment Conditions of Participation***:** CMS has been waiving certain physical environment requirements for Hospitals, CAHs, inpatient hospice, ICF/IIDs, and SNFs/NFs to reduce disruption of patient care and potential exposure/transmission of COVID-19. The physical environment regulations require that facilities and equipment be maintained to ensure an acceptable level of safety and quality. CMS will permit facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. (Waivers terminated at 418.110(c)(2)(iv) for inpatient hospice, 483.470(j) for ICF/IID and 483.90(a)(1) and (b) for SNFs/NF on 06-06-2022 per QSO-22-15-NH&NLTC&LSC).

- *Specific Physical Environment Waiver Information:* 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs all required these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS temporarily modified these requirements to the extent necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment. (Waivers terminated at 418.110(c)(2)(iv) for inpatient hospice, 483.470(j) for ICF/IID and 483.90(a)(1) and (b) for SNFs/NF on 06-06-2022 per QSO-22-15-NH&NLTC&LSC).

- 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs required these facilities to be in compliance

with the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). CMS temporarily modified these provisions to the extent necessary to permit these facilities to adjust scheduled ITM frequencies and activities required by the LSC and HCFC. The following LSC and HCFC ITM are considered critical are not included in this waiver:

- Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing.
- Portable fire extinguisher monthly inspection.
- Elevators with firefighters' emergency operations monthly testing.
- Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
- Means of egress daily inspection in areas that have undergone construction, repair, alterations or additions to ensure its ability to be used instantly in case of emergency. (**Waivers terminated at 418.110(c)(2)(iv) for inpatient hospice, 483.470(j) for ICF/IID and 483.90(a)(1) and (b) for SNFs/NF on 06-06-2022 per QSO-22-15-NH&NLTC&LSC).**

- 42 CFR §483.470(e)(1)(i) for ICF/IIDs, and §483.90(a)(7) for SNFs/NFs required these facilities to have an outside window or outside door in every sleeping room. CMS permitted a waiver of these outside window and outside door requirements to permit these providers to utilize facility and non-facility space that is not normally used for patient care to be utilized for temporary patient care or quarantine. **(Waivers terminated §483.470(e)(1)(i) for ICF/IID and §483.90(a)(7) for SNFs/NFs on 06-06-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Specific Life Safety Code (LSC) for Multiple Providers*: CMS has been waiving and modifying particular waivers under 42 CFR §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS modified these requirements as follows:
  - *Alcohol-based Hand-Rub (ABHR) Dispensers*: We are waiving the prescriptive requirements for the placement of alcohol-based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident populations to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area.

Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs. **CMS will end this waiver at the conclusion of the PHE.**

- *Fire Drills*: Due to the inadvisability of quarterly fire drills that move and mass staff together, CMS permitted a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6. **(Waivers terminated for fire drills at §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs; and §483.90(a) for SNF/NFs on 06-06-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Temporary Construction*: CMS waived requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2. **(Waivers terminated for temporary construction at §418.110(d) for inpatient hospice; §483.470(j) for ICF/IIDs; and §483.90(a) for SNF/NFs on 06-06-2022 per QSO-22-15--NH&NLTC&LSC.)**

Workforce

Physician Services: CMS provided relief to long-term care facilities related to provision of physician services through the following actions:

- Physician Delegation of Tasks in SNFs: 42 CFR 483.30(e)(4). CMS has waived the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver has given physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 CFR 491.2 or, in the case of a clinical nurse specialist, is licensed as such by the state and is acting within the scope of practice laws as defined by state law. We temporarily modified this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver did not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under state law or by the facility's own policy. **(This waiver terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Physician Visits:* 42 CFR 483.30(c)(3). CMS waived the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We modified this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs),

physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state and performing within the state's scope of practice laws. **(This waiver was terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Note to Facilities:* These actions assisted in potential staffing shortages, maximized use of medical personnel, and protecting the health and safety of residents during the PHE. We note that CMS did not waive the requirements for the frequency of required physician visits at § 483.30(c)(1). As set out above, we only modified the requirement to allow for the requirement to be met by an NP, physician assistant, or clinical nurse specialist, and via telehealth or other remote communication options, as appropriate. In addition, we note that we did not waive our requirements for physician supervision in § 483.30(a)(1), and the requirement at § 483.30(d)(3) for the facility to provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. It is important that the physician be available for consultation regarding a resident's care. **(This waiver terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Training and Certification of Nurse Aides:* CMS waived the requirements at 42 CFR §483.35(d), (except for 42 CFR §483.35(d)(1)(i)), which required that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under §483.35(d). CMS had waived these requirements to assist in potential staffing shortages seen with the COVID-19 pandemic. To ensure the health and safety of nursing home residents, CMS did not waive §483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. We further note that we did not waive §483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care. Achieving adequate staffing levels may be a concern for SNFs and NFs during the public health emergency. CMS temporarily waived these requirements so they do not present barriers for SNFs and NFs to hire staff; the temporary waiver helped these facilities provide adequate levels of staffing for the duration of the COVID-19 pandemic. **(This waiver terminated on 06-06-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Paid Feeding Assistants***:** CMS modified the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS modified the minimum timeframe requirements in these sections, which require this training to be a minimum of eight hours. CMS modified to allow that the training can be a minimum of one hour in length. CMS did not waive any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the required training content at 42

CFR §483.160(a)(1)-(8), which contains infection control training and other elements. Additionally, CMS did not waive or modify the requirements at 42 CFR §483.60(h)(2)(i), which requires that a feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). **(This waiver terminated on 06-06-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *In-Service Training*: CMS modified the nurse aide training requirements at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually. In accordance with section 1135(b)(5) of the Act, we postponed the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes. **(This waiver terminated on 06-06-2022 per QSO-22-15-NH&NLTC&LSC.)**

- *Clinical Records*: Pursuant to section 1135(b)(5) of the Act, CMS modified the requirement at 42 CFR §483.10(g)(2)(ii), which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident). Specifically, CMS modified the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days. **(This waiver terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC.).**

  Director of Food and Nutrition Services (New as of 11/26/21): CMS is issuing an 1135 waiver for 42 CFR 483.60(a)(1) and 483.60(a)(2) that requires dietitians hired or contracted with prior to November 28, 2016, to meet the specified requirements no later than five years after November 28, 2016 or as required by state law and to designate a person to serve as the director of food and nutrition services who, for designations prior to November 28, 2016, meets the specified requirements no later than five years after November 28, 2016, or no later than one year after November 28, 2016 for designations after November 28, 2016. The specified requirements involve specialized education or training in food service management and safety resulting in an associate's or higher degree in hospitality or food service management, a bachelor's or higher degree granted by a regionally accredited college or university in the United States, a certified dietary manager, or a certified food service manager. These educational and training requirements range in length, at a minimum, of 18 months to four years. It has been unusually challenging for these requirements to be met due to the COVID-19 Public Health Emergency (PHE). Therefore, CMS has been waiving this requirement due to the inability for individuals to enroll in, attend, or complete a certification program due to circumstances related to the COVID-19 PHE. *(Terminated on 10-01-2022 per*

- *Established new requirements for Long Term Care Facilities to Conduct SARS-CoV-2 Testing for Staff and Residents*: Under the new 483.80(h) CMS is requiring Long-Term

Care (LTC) Facilities to test Staff and Residents. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the Secretary. This rule will enhance efforts to keep COVID-19 from entering and spreading through nursing homes. These regulations are effective on September 2, 2020. Applicability date: **These regulations are applicable for the duration of the PHE for COVID–19. Note that section 488.447 is applicable one year beyond the expiration of the PHE for COVID–19.**

Medicare Telehealth

- *Physician Visits*: 42 CFR 483.30(c)(3). CMS waived the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We modified this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state and performing within the state's scope of practice laws**. (This waiver terminated on 05-07-2022 per QSO-22-15-NH&NLTC&LSC.)**

Additional Guidance

- The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

- CMS has released guidance to describe standards of practice for infection control and prevention of COVID-19 at https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

- CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf

- Additional COVID-19 resources for long-term care facilities are available at https://www.cms.gov/nursing-homes.