

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

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expand its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Patients Over Paperwork

- **Physical Environment:** Provided that the State has approved the location as one that sufficiently addresses safety and comfort for patients and staff, CMS is waiving requirements under 42 CFR §483.90 to allow for a non-SNF buildings 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 believes this will also provide another measure that will free up inpatient care beds at hospitals for the most acute patients while providing beds for those still in need of care. CMS will waive certain conditions of participation and certification requirements for opening a 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 is also temporarily allowing 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 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.

Transfers of COVID-19 Patients: CMS is waiving certain requirements in 42 CFR §483.10, §483.15, and §483.21 to allow a long term care (LTC) facility to move residents within a facility, or transfer resident(s) to another LTC facility solely for the purposes of cohorting and separating residents with and without COVID-19. This is consistent with recent CDC guidance, and helps residents with COVID-19 by placing them in units or facilities that are prepared to care for them. It also helps residents without COVID-19 by placing them in units or facilities without other COVID-19 residents, thus helping to protect them from being infected.

- *3- Day Prior Hospitalization:* Using the waiver authority under Section 1812(f) of the Social Security Act, CMS is waiving the requirement for a 3-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, for those people who experience dislocations, or are otherwise affected by this emergency. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.
- *Reporting Minimum Data Set:* CMS is waiving 42 CFR §483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.
- *Staffing Data Submission:* CMS is waiving 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.
- *Waive Pre-Admission Screening and Annual Resident Review (PASRR):* CMS is 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.
- *Resident Groups:* CMS is waiving the requirements at §483.10(f)(5) to allow for residents to have the right to participate in-person in resident groups. This waiver would only permit 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.
- *Accelerated/Advance Payments:* In order to increase cash flow to providers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process here: www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.
- *Provider Enrollment:* CMS has established toll-free hotlines for all providers and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. In addition, the following flexibilities are provided for provider enrollment:
 - » Waive certain screening requirements.
 - » Postpone all revalidation actions.
 - » Expedite any pending or new applications from providers.

Medicare appeals in Fee for Service, Medicare Advantage (MA) and Part D

- CMS is 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 562, 42 CFR 423.562, 42 CFR 422.582 and 42 CFR 423.582 to allow extensions to file an appeal;

- CMS is 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; 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), § 422.572(b)(1) and § 422.590(f)(1);
- CMS is allowing MACs and QICs in the FFS program 42 C.F.R 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 42 CFR § 422.561, 42 CFR § 423.560. However, any communications will only be sent to the beneficiary;
- CMS is 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 using information that is available 42 CFR § 422.562, 42 CFR § 423.562.
- CMS is 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, 42 CFR 422.562, 42 CFR 423.562 to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

Cost Reporting

- CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak; 42 CFR § 413.24(f)(2)(ii) allows this flexibility. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

CMS Facility without Walls (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.

Workforce

- *Training and Certification of Nurse Aids:* CMS is waiving the requirements at 42 CFR §483.35(d), (except for 42 CFR §483.35(d)(1)(i)), which require 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 is waiving 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 is not waiving §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 are not waiving §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 is temporarily waiving these requirements so they do not present barriers for SNFs and NFs to hire staff; the temporary waiver will help these facilities provide adequate levels of staffing for the duration of the COVID-19 pandemic.

Medicare Telehealth

- *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.

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/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting>

