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

*** Indicates items added or revised in the most recent update*

Since the beginning of the COVID-19 Public Health Emergency, the Centers for Medicare & Medicaid Services has issued 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. 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) ensure all Americans have access to a COVID-19 vaccine;
2) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states;
3) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites;
4) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home;
5) expand in-place testing to allow for more testing at home or in community based settings; and
6) 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.

***Ensuring all Americans Have Access to a COVID-19 Vaccine***

On October 28, 2020, CMS released an Interim Final Rule with Comment Period (IFC) that establishes that any vaccine that receives Food and Drug Administration (FDA) authorization, through an Emergency Use Authorization (EUA) or licensed under a Biologics License Application (BLA), will be covered under Medicare as a preventive vaccine at no cost to beneficiaries. The IFC also implements provisions of the CARES Act that ensure swift coverage of a COVID-19 vaccine by most private health insurance plans without cost sharing from both in and out-of-network providers during the course of the public health emergency (PHE).

After the FDA either approves or authorizes a vaccine for COVID-19, CMS will identify the specific vaccine codes, by dose if necessary, and specific vaccine administration codes for each dose for Medicare payment. CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines.

The Medicare payment rates for COVID-19 vaccine administration will be $28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of 2 or more doses, the initial dose(s) administration payment rate will be $16.94, and $28.39 for the administration of the final dose in the series. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and

spending additional time with patients answering any questions they may have about the vaccine. Medicare beneficiaries, those in Original Medicare or enrolled in Medicare Advantage, will be able to get the vaccine at no cost.

For calendar years 2020 and 2021, Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in Medicare Advantage (MA) plans. Providers should submit COVID-19 claims to Original Medicare for all patients enrolled in MA in 2020 and 2021. MA plans will not be responsible for reimbursing providers to administer the vaccine during this time. MA beneficiaries also pay nothing for COVID-19 vaccines and their copayment/ coinsurance and deductible are waived.

CMS is working to increase the number of providers that will administer a COVID-19 vaccine to Medicare beneficiaries when it becomes available, to make it as convenient as possible for America's seniors. New providers are now able to enroll as a "Medicare mass immunizers" through an expedited 24-hour process. The ability to easily enroll as a mass immunizer is important for some pharmacies, schools, and other entities that may be non-traditional providers or otherwise not eligible for Medicare enrollment. To further increase the number of providers who can administer the COVID -19 vaccine, CMS will continue to share approved Medicare provider information with states to assist with Medicaid provider enrollment efforts. CMS is also making it easier for newly enrolled Medicare providers also to enroll in state Medicaid programs to support state administration of vaccines for Medicaid recipients.

For more information, view our COVID-19 vaccine toolkits for providers, private health plans and state Medicaid programs at www.cms.gov/covidvax.

*****Coverage for Monoclonal Antibody Therapies***

The Food and Drug Administration has issued emergency use authorizations (EUA) for monoclonal antibody therapies 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. During the COVID-19 public health emergency (PHE), Medicare will cover and pay for these infusions the same way it covers and pays for COVID-19 vaccines (when furnished consistent with the EUA). This will allow a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract for this, to administer these treatments in accordance with each product's EUA and in accordance with any state scope of practice and licensure requirements. Please refer to Section BB of the COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing document for more information about coverage for COVID-19 Monoclonal Antibody Therapies.

In order to ensure immediate access during the COVID-19 PHE, there is no beneficiary cost sharing and no deductible for monoclonal antibody COVID-19 products to treat COVID-19 when administration is provided in a Medicare-enrolled care setting (consistent with Section 3713 of the CARES Act).

*Coding and Payment*: CMS has identified specific billing code(s) for each of the authorized COVID-19 monoclonal antibody products and specific administration code(s) for Medicare

payment. When the monoclonal antibody COVID-19 product is given to providers and suppliers for free, the HCPCS code for the monoclonal antibody product should **not** be included on the claim. Because Medicare will cover and pay for these infusions the same way it covers and pays for COVID-19 vaccines, COVID-19 monoclonal antibody products are not eligible for the New COVID-19 Treatments Add-on Payment (NCTAP) under the Inpatient Prospective Payment System (IPPS). Initially, for the infusions of bamlanivimab or casirivimab and imdevimab (administered together), the Medicare national average payment rate for the administration will be approximately $310. This payment rate is based on one hour of infusion and post-administration monitoring in the hospital outpatient setting. Should additional products come to market, get the most up to date list of billing codes, payment allowances and effective dates.

*Provider Enrollment*: Health care providers administering the COVID-19 monoclonal antibody infusions will follow the same Medicare enrollment process as those administering the COVID-19 vaccines. Review information about provider enrollment.

*Enforcement Discretion:* In order to facilitate the ***efficient*** administration of COVID-19 monoclonal antibody products to SNF residents, CMS will exercise enforcement discretion with respect to certain statutory provisions as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance (collectively, "SNF Consolidated Billing Provisions"). Through the exercise of that discretion, CMS will allow Medicare-enrolled immunizers including, but not limited to, pharmacies working with the United States, as well as infusion centers, and home health agencies to bill directly and receive direct reimbursement from the Medicare program for administering this treatment to Medicare SNF residents.

*Additional Resources:*

For specific instructions on how to bill the Medicare program for monoclonal antibody treatments, please see the Monoclonal Antibody Program Instruction.

View an infographic on coverage of monoclonal antibody therapies at https://www.cms.gov/files/document/covid-infographic-coverage-monoclonal-antibody-products-treat-covid-19.pdf.

***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/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 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 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 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.

- *3- Day Prior Hospitalization*: Using the waiver authority under Section 1812(f) of the Social Security Act, CMS is temporarily 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. In addition, for certain beneficiaries who exhausted their SNF benefits, it authorizes 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."
- *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~~. 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 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.
- *Quality Assurance and Performance Improvement (QAPI).* CMS is modifying certain requirements in 42 CFR §483.75, which requires long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §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 will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.
- *In-Service Training*: CMS is modifying 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 are postponing 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.

- *Detailed Information Sharing for Discharge Planning for Long-Term Care (LTC) Facilities.* CMS is waiving the discharge planning requirement in §483.21(c)(1)(viii), which requires 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 is to provide facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result 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 address the resident's goals of care and treatment preferences.
- *Clinical Records*. Pursuant to section 1135(b)(5) of the Act, CMS is modifying 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 is modifying the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days.
- *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.

***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.

***Payment***

- *Accelerated/Advance Payments*: In order to provide additional cash flow to healthcare providers and suppliers impacted by COVID-19, CMS expanded and streamlined the Accelerated and Advance Payments Program, which provided conditional partial payments to providers and suppliers to address disruptions in claims submission and/or claims processing subject to applicable safeguards for fraud, waste and abuse. Under this program, CMS made successful payment of over $100 billion to healthcare providers and suppliers. As of April 26, 2020, CMS is reevaluating all pending and new applications for the Accelerated Payment Program and has suspended the Advance Payment Program, in light of direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund. Distributions made through the Provider Relief Fund do not need to be repaid. For providers and suppliers who have received accelerated or advance payments related to the COVID-19 Public Health Emergency, CMS will not pursue recovery of these payments until 120 days after the date of payment issuance. Providers and suppliers with questions regarding the repayment of their accelerated or advance payment(s) should contact their appropriate Medicare Administrative Contractor (MAC).
- *Requirement for Hospitals and CAHs to report COVID-19 Data*. Hospitals and CAHs are to report information in accordance with a frequency and in a standardized format as specified by the Secretary during the PHE for COVID-19. More information is available at https://www.hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf.

**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. We are currently authorizing delay for the following fiscal year end (FYE) dates. 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 revised extended cost report due date for FYE 12/31/2019 will be August 31, 2020. For the FYE 01/31/2020 cost report, the extended due date is August 31, 2020. For the FYE 02/29/2020 cost report, the extended due date is September 30, 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.
- *Resident Transfer and Discharge:* CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b)(2)(i) (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; or

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 to be 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 are only waiving the requirement, under § 483.15(c)(3), (c)(4)(ii), (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, we are only waiving 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 expect 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.
   - 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," as 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. 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 is waiving the requirements in 42 CFR 483.10(e)(5), (6), 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, to provide notice and rationale for changing a resident's room, 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 is 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.

*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 require these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS is temporarily modifying 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.
- 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 require these facilities to be in compliance with the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). CMS is temporarily modifying 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.

- 42 CFR §483.470(e)(1)(i) for ICF/IIDs, and §483.90(a)(7) for SNFs/NFs require these facilities to have an outside window or outside door in every sleeping room. CMS will permit 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.
- *Specific Life Safety Code (LSC) for Multiple Providers*. CMS is waiving and modifying particular waivers under 42 CFR §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying 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 population 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.
  - Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit 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.
  - Temporary Construction: CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.

***Workforce***

- *Physician Services:* CMS is providing 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 is waiving 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 gives 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 are temporarily modifying this

regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does 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.

- *Physician Visits:* 42 CFR 483.30(c)(3). CMS is waiving 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 are modifying 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.
- *Note to Facilities:* These actions will assist in potential staffing shortages, maximize the use of medical personnel, and protect the health and safety of residents during the PHE. We note that we are not waiving the requirements for the frequency of required physician visits at § 483.30(c)(1). As set out above, we have 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 are not waiving 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.

- *Training and Certification of Nurse Aides:* 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.
- *Paid Feeding Assistants*: CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS is modifying the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the training can be a minimum of 1 hour in length. CMS is not waiving 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 is also not waiving or modifying 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).

- *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.

***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/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf