

CMS Issues Blanket Regulatory Waivers

The Centers for Medicare and Medicaid Services (CMS) has issued [several blanket waivers for long term care providers](#) in pages 9-12. The following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration.

To learn more, you can attend a National Stakeholder Call CMS is holding tomorrow (Tuesday, March 31) at 12:00 PM EDT.

Participant Dial In: 877-251-0301
Conference ID: 7786289
Audio Webcast: [REGISTER](#)

We also offer a summary below.

Nurse Aide Training Requirements and Creating COVID-19 Segregated Buildings

Training and Certification of Nurse Aides

To assist in addressing staffing shortages due to the COVID-19 pandemic, CMS is waiving the requirements that a facility may not employ anyone for longer than four months unless they meet certain training and certification requirements. This waiver allows nursing centers to temporarily employ individuals who have completed alternative training paths, as long as they are competent to provide relevant nursing and nursing related services.

To fill this need, AHCA/NCAL is offering an 8-hour online [Temporary Nurse Aide](#) training course free to all providers as soon as all required state approvals, such as state occupational licensing and state regulatory requirements, are received.

Resident Groups

CMS is waiving the requirements regarding resident participation in in-person resident groups, considering recommendations of social distancing and limiting social gatherings to prevent the spread of COVID-19.

Resident roommates and grouping

CMS is waiving requirements in order to permit 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. Specifically, this waives the requirements 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.

The following waivers have specific conditions to them and may not apply to all providers:

Physical Environment

CMS is waiving requirements in this section for providers who are implementing surge plans. This waiver does not apply for daily operations.

- CMS is waiving requirements to allow for a non-SNF building to be temporarily certified 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.
- **States must first approve the location** can sufficiently address safety and comfort for patients and staff before this waiver can be utilized by providers.
- CMS is also waiving requirements to temporarily allow 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 care in emergencies and situations to help with surge capacity.
- Providers must ensure this is consistent with their state's emergency preparedness or pandemic plan, or as directed by the local or state health department.

Resident Transfer and Discharge

CMS is waiving some requirements in this area to allow for facilities to transfer or discharge residents to another facility for these three 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; 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.

There are several exceptions for these waived requirements on page 11 of the CMS document.

- 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.
- CMS is only waiving the requirement that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to § 483.10 are not waived.
 - CMS is only waiving the requirement 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.
 - CMS is only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above.
 - These requirements are also waived when 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.

Providers are reminded 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 are protected.

CMS also reminds states in an emergency, the State has the authority to transfer Medicaid and Medicare residents to another facility.

Reimbursement-Related Waivers

Section 1812(f) -- 3-Day and Spell of Illness Waivers

CMS has reiterated these national, blanket waivers. CMS’ language has not changed. The Agency states, “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.”

Formerly State-by-State Section 1135 PASRR Waiver

Prior to today’s blanket waiver, CMS had approved waivers of Pre-Admission Screening and Resident Review (PASRR). CMS now is nationally allowing states and nursing homes to suspend these assessments for new residents for 30 days, waiving 42 CFR 483.20(k). 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.

Medicare 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:

1. waive certain screening requirements;
2. postpone all revalidation actions; and
3. expedite any pending or new applications from providers.

Cost Reporting

Previously, CMS had left cost reporting extensions to Local Administrative Contractors (MAC) decision making. With today's blanket waiver, CMS is delaying the filing deadline of certain cost report due dates as follows:

Cost Reports	Previous Deadline	New Deadline
FYE October 31, 2019	March 31, 2020	June 30, 2020
FYE November 30, 2019	April 30, 2020	June 30, 2020
FYE December 31, 2019	May 31, 2020	July 31, 2020

Medicare Appeals in Fee for Service (FFS), Medicare Advantage (MA)

CMS is granting authority under Parts A, B, C, and D for contractors and plans to grant appeal flexibilities.

Expanding availability of end stage renal disease (ESRD) to Nursing Home Residents

CMS is waiving the following requirements related to nursing home residents:

1. **Furnishing dialysis services on the main premises** – CMS is waiving the requirement for dialysis facilities to provide services directly at their location to allow dialysis facilities to provide service to its patients in the nursing home or skilled nursing facility. CMS continues to require that services provided to these nursing home residents are under the direction of the same governing body and professional staff as the resident's usual Medicare-certified dialysis facility. Further, in order to ensure that care is safe, effective and is provided by trained and qualified personnel, CMS requires that the dialysis facility staff: furnish all dialysis care and services, provide all equipment and supplies necessary, maintain equipment and supplies in the nursing home, and complete all equipment maintenance, cleaning and disinfection using appropriate infection control procedures and manufacturer's instructions for use; and
2. **Clarification for billing procedures.** Typically, ESRD beneficiaries are transported from a SNF/NF to an ESRD facility to receive renal dialysis services. In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition. The ESRD provider would need to have their trained personnel

administer the treatment in the SNF/NF. In addition, the provider must follow the CFCs. In particular, under the CFCs is the requirement that to use a dialysis machine, the FDA-approved labeling must be adhered to § 494.100 and it must be maintained and operated in accordance with the manufacturer's recommendations (§ 494.60) and follow infection control requirements at § 494.30.

CMS Facility without Walls (Temporary Expansion Sites) Transfers of COVID-19 Patients

A long term care 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](#) 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.

Requirements of Participation Waivers

Minimum Data Set

CMS is providing relief on the timeframe requirements for Minimum Data Set assessments and transmission.

Staffing Data Submission

CMS is providing relief to long-term care facilities on the requirements for submitting staffing data through the Payroll-Based Journal system.

Physician Visits

CMS is waiving the requirement for physicians and non-physician practitioners to perform in-person visits and to support previously announced flexibilities to allow visits to be conducted, as appropriate, via telehealth options.

Email COVID19@ahca.org for additional questions, or visit ahcancal.org/coronavirus for more information.

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