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# FOCUS POINT NEWSLETTER
# SPECIAL FOCUS POINT – COVID 19 ALERT 3/31/20

## COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

- **3-Day Prior Hospitalization** CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a SNF stay, which provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experience dislocations, or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (this waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).
- **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. F-851
- **Pre-Admission Screening and Annual Resident Review** (PASARR). CMS is waiving 42 CFR 483.20(k) 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.
- **Physical Environment** CMS is waiving requirements related at 42 CFR 483.90, specifically the following:
  - 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 § 483.90 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 are 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**.**
    - CMS is also waiving requirements under 42 CFR 483.90 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 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.
- **Resident Groups** CMS is waiving the requirements at 42 CFR 483.10(f)(5), which ensure residents can participate in-person in resident groups. This waiver would only permit the facility to restrict 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.

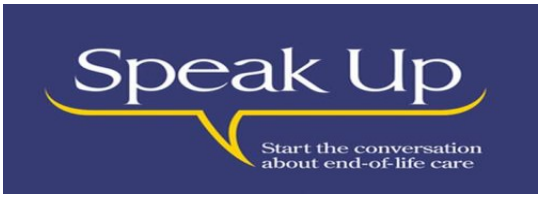
- **Training and Certification of Nurse Aides** CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d). 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 42 CFR § 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.
- **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.
- **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.
- **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) to allow a long term care (LTC) facility to transfer or discharge residents to another LTC facility solely for the following cohorting purposes:
    - Transferring residents <u>with symptoms</u> 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.
    - Transferring residents <u>without symptoms</u> 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
    - Transferring residents <u>without symptoms</u> 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 **<u>only waived</u>** 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 **<u>only waiving</u>** 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 are not waived. 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 **<u>only waiving</u>** 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 the 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 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.

CMS reminded 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. The also reminded 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.

## Advance Care Planning – More Important Now




*"Advance care planning is about planning for the 'what ifs' that my occur across the entire lifespan."– Joanne Lynn MD*

Whether someone is facing an acute illness, a long-term chronic illness or a terminal illness, advance care planning can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision making challenges facing the resident and/or the legal representatives. The vast majority of our residents want:

- To have their pain and symptoms controlled
- To have their wishes known and honored
- To be treated as a whole person with appropriate psychosocial and spiritual support
- To know that family are important and will be care for

However these "wants" are not always clearly defined or documented.

The default practice in our medical system is to provide an aggressive "do everything possible" care unless there is a clear well documented Advance Directive. When Advance Care Planning is not completed and Advance Directives established, many of our resident could be hospitalized, isolated, alone, experiencing pain and discomfort and die. Families and loved ones are devasted emotionally and financially. A key part of the problem is our society's denial of death and dying, and of being in a circumstance in which we are unable to make our own decisions and speak for ourselves. *"Denial about death does a disservice of not dealing with life-review and life-*

*closure issues that some people would choose to do if they were thinking about dying as part of the last phase."* – Judith Peres, MSW. So honor your residents by removing the denial and clear up the confusion. Give your residents the respect and dignity of having an Advance Care Plan that gives them a voice and a way to make choice as to what their wishes are and who can make the decisions on their behalf, if they are unable to do so. It is the least we can in this time in our would of the unknown.

## CMS Issues Guidance for Use of Telehealth – 3/28/20

has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The guidance includes an easy to use Toolkit which can be downloaded at: https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. Nursing homes do not need to apply for a waiver to use telehealth and telemedicine services. There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries:

| TYPE OF SERVICE | WHAT IS THE SERVICE? | HCPCS/CPT CODE | Patient Relationship with Provider |
|---|---|---|---|
| **MEDICARE TELEHEALTH VISITS** | A visit with a provider that uses telecommunication systems between a provider and a patient. | Common telehealth services include:<br>• 99201-99215 (Office or other outpatient visits)<br>• G0425–G0427 (Telehealth consultations, emergency department or initial inpatient)<br>• G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs)<br>For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes | For new* or established patients.<br>*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency |
| **VIRTUAL CHECK-IN** | A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient. | • HCPCS code G2012<br>• HCPCS code G2010 | For established patients. |
| **E-VISITS** | A communication between a patient and their provider through an online patient portal. | • 99421<br>• 99422<br>• 99423<br>• G2061<br>• G2062<br>• G2063 | For established patients. |

## Personal Assistants - A Training and Task Guide

In collaboration with Chiles Healthcare Consulting, VHCA developed the Personal Assistants - A Training and Task Guide (word version) as a tool for facilities which are hiring and training these additional staff members. This guide represents a compilation of resources that are intended to provide long term care facilities with the necessary educational tools and some recommended tasks that are appropriate for a personal assistant. This document is available at no charge to all nursing homes / assisted living facilities.

The personal assistant role may be known as other titles throughout the industry (e.g., hospitality aide, customer service associate, ancillary services associate, etc.) This guide is intended to supplement the facility's existing practices and protocols. It includes examples of education material that may be used during orientation of Personal Assistants as well as a sampling of step by step task assignments that the facility may find appropriate for the employees. The tools within this resource are provided to you in a format that you can easily modify to meet the unique needs, characteristics, protocols, and practices of your facility. Adoption of any education or task tools should be carefully reviewed by the facility's leadership and clinical management team prior to implementation. If you have questions regarding this guide or any of the tools, please contact April Payne april.payne@vhca.org or Mary Chiles at mary@chileshealthcare.com

### New and/or Available CHC Resources for COVID 19

CHC is pleased to offer the following resources that have been developed throughout this pandemic. Please contact Mary for information or to request a copy. As this pandemic evolves, we will continue to develop resources that may be helpful to you. If you have specific needs or suggestions for a resource or tool that you could utilize, please contact Mary.

- Sample care plans [appropriate for nursing facility or assisted living facility] – these are provided at no charge on request
    - Risk of Expose / Transmission of COVID-19 [appropriate for all residents]
    - Risk of Anxiety, Fear, Depression related to COVID-19 [appropriate for all residents but should be modified to reflect specific interventions being utilized; should address any allowed visitors]
    - NEW -- Care of Residents with Suspected / Confirmed COVID-19 [new admissions / current residents who have suspected/confirmed COVID-19
- Other Resources – available on request at identified cost
    - Emergent Infectious Disease Package [includes "novel "infection, Ebola and Zika] at $75
    - NEW -- Emergent Infectious Disease policy specific for Virginia Assisted Living Facilities at $50
    - COVID-19 Implementation Timeline at $50