IHCA GUIDE TO THE END OF THE PUBLIC HEALTH EMERGENCY FOR SKILLED NURSING FACILITIES

At the beginning of the COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) and other government agencies used emergency waivers and various regulatory authorities to provide flexibility to long-term care providers. These regulatory and payment waivers allowed providers to respond rapidly to meet the needs of individuals impacted by the COVID-19 pandemic. With the federal public health emergency concluding on May 11, 2023, IHCA has developed this document to provide a comprehensive outline of these flexibilities and guidance to assist in the reestablishment of certain health and safety standards and other financial and program requirements. The details of each flexibility and information related to their conclusion are outlined in this document. As more information becomes available from CMS and other regulatory bodies, IHCA will update this document to reflect current guidance.

The 1135 COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers included many flexibilities commonly utilized by long-term care providers. At different times throughout the pandemic, CMS announced the expiration of several waivers held within the 1135 blanket waiver. This document will outline specific flexibilities and provide a framework for continued facility operation after May 11, 2023.

CMS announced their intent, in QSO-23-13-ALL, to end the COVID-19 vaccination requirement (mandate) with the end of the federal PHE. However, at the time this document was published, no further information had been provided by CMS and members are encouraged to comply until further guidance is issued.

Regulatory and Payment Flexibilities Related to the 1135 CMS COVID-19 Emergency Blanket Waiver

Three-Day Prior Hospitalization

Using the authority under Section 1812(f) of the Act, CMS waived the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay, which provided temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who experienced dislocations, or were otherwise affected by COVID-19. In addition, for certain beneficiaries who had exhausted their SNF benefits, it authorized renewed SNF coverage without first having to start a new benefit period (this waiver only applied to those beneficiaries who had 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).

- Beginning May 12, 2023, Medicare beneficiaries seeking a new admission no longer qualify for SNF services without a three-day hospitalization.
- Beneficiaries admitted to the facility under the three-day stay waiver and receiving skilled nursing benefits in the facility on May 12, 2023, can continue to receive uninterrupted services.

- Beneficiaries admitted to the SNF under waiver provisions (without a 3-day hospitalization) who are discharged for more than three days will NOT qualify for readmission within the 30-day readmission window without a 3-day hospital stay.
- If a beneficiary qualified for the special one-time renewal of SNF benefits while the waiver is in effect, that reserve of 100 additional SNF benefit days would remain available for the beneficiary to draw upon even after the waiver has expired.
- For residents admitted under the 3-day stay or obtaining a benefit period waiver on or before May 11 2023, CMS has instructed providers to continue using the DR condition code for any claims during that 100-day benefit period for services furnished May 12 and beyond, until discharged from Part A, or their 100-day benefits have been exhausted.
- CMS provides additional NF/SNF-specific guidance regarding the end of the PHE here.
- Medicare Advantage plans can determine eligibility rules specific to their plans. Members should communicate directly with their account representatives to determine the eligibility guidelines for each plan.

Waive Pre-Admission Screening and Annual Resident Review (PASARR)

CMS waived 42 CFR483.20(k), allowing nursing homes to admit new residents who had not received level one or level two Preadmission Screening. Level one assessments could be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to state PASARR program for level two Resident Review.

- Beginning May 12, 2023, residents admitted to nursing facilities must have a level 1 or 2 PASSR screening completed prior to admission.

Resident Roommates and Grouping

CMS waived the requirements in 42 CFR 483.10(e) (5) 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 waived a facility's requirement, 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.

- Beginning May 12, 2023, nursing facilities are required to allow residents to share a room with a roommate of their choice when practicable and when both residents consent to the arrangement.
- Beginning May 12, 2023, residents will retain the right to refuse a transfer to another room of the facility which is not subject to payor rules and is addressed in the organization's policies.

Telehealth

In the 1135 CMS COVID-19 Emergency Blanket Waiver, CMS provided two waivers allowing telehealth, as noted here:

Eligible Practitioners

Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists and others, to receive payment for Medicare telehealth services. This waiver ends 151 days after the conclusion of the federal PHE.

Audio-Only Telehealth for Certain Services

Pursuant to authority granted under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the Act and 42 CFR §410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes). Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner. This waiver will end 151 days after the conclusion of the PHE.

Telehealth continues to be allowable for Medicare-covered services until December 31, 2024, as the Consolidated Appropriations Act, 2023, extended these flexibilities* until that date. This remains in effect regardless of the status of the federal public health emergency.

*SNF providers are reminded that the CMS waiver for required physician visits ended on May 7, 2022. This waiver allowed SNFs to provide the required physician visits as identified in 42 CFR 483.30 via telehealth. Since the date of waiver expiration, in-person physician visits have been required for those visits which are identified in F712 (page 456) of Appendix PP, State Operations Manual. Physician visits that are not required within this rule can be conducted via telehealth.

Note regarding physical, occupational, and/or speech therapy being provided via telehealth:
Although Section 4113 of the Consolidated Appropriations Act of 2023 (P.L. 117-328) directed CMS to extend the beneficiary access to therapy services furnished via telehealth services initiated during the PHE through the end of 2024, the agency has not provided specific guidance to ensure that beneficiaries will continue to have access to these services when furnished by an institutional provider such as a hospital outpatient therapy department, skilled nursing facility, home health agency or outpatient rehabilitation facility. When clarification is provided by CMS, IHCA will provide updates as necessary.

HIPAA Patient Privacy Requirements

The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) announced that the Notifications of Enforcement Discretion issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act during the COVID-19 public health emergency would expire at 11:59 pm on May 11, 2023, due to the expiration of the COVID-19 public health emergency. OCR is providing a 90-calendar day transition period for covered health care providers to come into compliance with the HIPAA Rules with respect to their provision of telehealth. This policy change will no longer permit providers to use technology such as unsecure iPads, smart phones, or other technology for telehealth services unless they meet the stringent HIPAA patient privacy requirements after August 9, 2023. Learn more here.

Life Safety Code (LSC) Flexibilities Related to the 1135 CMS COVID-19 Emergency Blanket Waiver

Alcohol-based Hand-Rub (ABHR) Dispensers

CMS waived 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, bulk containers (over five gallons) were still required to be stored in a protected hazardous materials area.

- Refer to: NFPA 101, 2012 Edition, Life Safety Code, sections 18/19.3.2.6 to understand specific ABHR requirements. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by §483.90(a)(4) for SNF/NFs.
- Beginning May 12, 2023, this waiver will end and nursing facilities will again be required to follow storage and access rules (found here) regarding ABHR.

Emergency Preparedness Regulations Waived by CMS (Not contained within the 1135 CMS COVID-19 Emergency Blanket Waiver)

Waiver of Full-Scale Exercises

The Centers for Medicare & Medicaid Services (CMS) released a new regulatory memo on May 1st, QSO-23-13-ALL , containing a section related to Emergency Preparedness, starting on page 2, stating that the following information supersedes the previously issued QSO-20-41-ALL-REVISED memo for all certified providers/ suppliers. CMS regulations for Emergency Preparedness (EP) require the provider/supplier to conduct exercises to test their EP plan to ensure that it works, and that staff are trained appropriately about their roles and the provider/supplier's processes. During or after an actual emergency, the EP regulations allow for a one-year exemption from the requirement that the provider/supplier perform testing exercises. The exemption only applies to the next required full-scale exercise (not the exercise of choice), based on the 12-month exercise cycle. The cycle is determined by the provider/supplier (e.g., calendar, fiscal or another 12-month timeframe). The exemption only applies when a provider/supplier activates its emergency preparedness program for an emergency event.

- Providers are expected to return to normal operating status and comply with regulatory requirements for emergency preparedness with the conclusion of the PHE, including conducting a full-scale exercise within its annual cycle for 2023 and an exercise of choice. The cycle is determined by the provider (e.g., calendar, fiscal, or another 12-month time).

New Requirements Established During the COVID-19 Pandemic

Long Term Care Facilities to Conduct SARS-CoV-2 Testing for Staff and Residents

QSO-20-38-NH, which previously required nursing facilities to test staff and residents for COVID-19, expired on May 11, 2023. However, QSO-20-39-NH directs nursing facilities to follow nationally accepted standards, such as CDC recommendations, which continue to recommend testing actions in some situations. Testing for COVID-19 per these recommendations will be considered to determine compliance with F880.

The Health and Human Services (HHS) program that distributes Abbott BinaxNOW tests to skilled nursing facilities and assisted living communities will continue after the end of the Public Health Emergency (PHE). HHS has not set an end date and is looking for opportunities to continue supporting facilities/communities with testing supplies. Requests to change or pause distributions of COVID-19 testing supplies can be sent to Binax.team@hhs.gov.

HHS will be shifting the shipments of point-of-care (POC) Abbott Binax cards to Abbott Binax over-the-counter tests (OTC). These two products are nearly identical in use and performance. The OTC tests will have at least 60 days until expiration at the time of delivery. The OTCs can be used as point-of-care in sites that have valid CLIA-waivers. Additionally, they can be self-administered by individuals who are capable.

As a reminder, facilities/communities must have an active CLIA waiver to receive shipments. Quantities received are based on CMS estimates of staffing, local transmission rates, and historical allocation quantities.

Required Facility Reporting

Under §483.80(g), long-term care facilities are required to report COVID-19 cases in their facility to the Centers for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) on a weekly basis. CDC and CMS used 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.

- The requirement for nursing facilities to report to NHSN **will continue until December 31, 2024**, although specific data requirements may change over time.

Facilities were required to notify residents, their representatives and families of residents in facilities of the status of COVID-19 in the facility, which included any new cases of COVID-19 as they were identified.

- CMS confirmed that the requirement at §483.80(g)(3) to notify all residents and their representatives about COVID-19 cases **ended Monday, May 1, 2023**, when QSO-23-13-ALL was issued. Facilities are no longer required to notify all residents and their representatives when there is a positive COVID case in the facility, or if there have been three more residents with new onset of respiratory symptoms occurring within 72 hours of each other. *Facilities are reminded that any change in condition continues to require notification, as referenced in F580.

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).

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
CMS also established an additional payment amount of approximately $35.50 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, and CMS geographically adjusts the additional amount and administration rate based on where the provider or supplier administers the vaccine.

Additional Payment for Administering the Vaccine in the Patient's Home After the End of the PHE
CMS will continue to pay a total payment of approximately $75 per dose to administer COVID-19 vaccines in the home for certain Medicare patients through the end of the calendar year that the PHE ends (2023).

Note: The Calendar Year 2023 Physician Fee Schedule proposed rule includes proposals that could impact these policies, and CMS is anticipated to issue the final rule later this year.

More information: COVID-19 vaccine toolkits

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

COVID-19 Monoclonal Antibodies

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 preexposure prophylaxis of COVID-19 in adults and pediatric patients with certain conditions.

During the COVID-19 public health emergency (PHE), 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.

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 biological products are paid under Section 1847A of the Social Security Act.
• Through the applicable payment system, using the appropriate coding and payment rates, similar to the way the administration of other complex biological products is paid.

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 VEKLURYTM (remdesivir) in the Outpatient Setting

As of April 25, 2022, the FDA updated the approval of VEKLURYTM (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**.

Note about Emergency Use Authorizations (EUA)
U.S. Food Drug Administration's (FDA) Emergency Use Authorizations (EUAs) for COVID-19 products (including tests, vaccines, and treatments) will not be affected. The ending of the COVID-19 PHE will not affect the FDA's ability to authorize various products, including tests, treatments, or vaccines for emergency use. Existing EUAs for COVID-19 products will remain in effect under Section 564 of the Federal Food, Drug, and Cosmetic Act, and the agency may continue to issue new EUAs going forward when criteria for issuance are met.

Payment Flexibilities

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 had 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 had 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)). With the COVID-19 PHE end, these flexibilities will continue to apply consistent with existing authority and requests for appeals must meet the existing regulatory requirements.

During the PHE, CMS had been allowing Medicare Administrative Contractors (MACs) and quality improvement committees (QICs) in the fee-for-service (FFS program) (42 CFR 405.910) and Medicare Advantage (MA) and Part D plans, as well as the Part C and Part D independent review entities (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. With the COVID-19 PHE ended, 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 no longer applies. 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 had 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). With the COVID-19 PHE ended, requests for appeals must meet the existing regulatory requirements.

During the PHE, CMS had 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. With the COVID-19 PHE ended, these flexibilities will continue to apply, consistent with existing regulatory authority.

Cost Reporting

CMS delayed the filing deadline for all provider types impacted during the COVID-19 PHE, including hospitals, SNFs, home health agencies (HHAs), hospices, end stage renal disease (ESRD) providers, rural health clinics (RHCs), federally qualified health centers (FQHCs), community mental health centers (CMHCs), organ procurement organizations (OPOs), histocompatibility labs and home office cost statements, with a fiscal year ending on or between October 31, 2019, through December 31, 2020. Providers that continue to experience the impacts of the COVID-19 PHE and require additional time to file their cost report ending after December 31, 2020, may submit a request to their MAC in accordance with CMS 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.

Additional Resources:

Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap

Fact Sheet: CMS COVID-19 Waivers and Flexibilities for Long-Term Care Facilities

Billing & Coding Guidance: Frequently Asked Questions to Assist Medicare Providers

Medicaid Continuous Coverage

From March 2020, through April 1, 2023, Iowa Medicaid was required to maintain continuous health care coverage for beneficiaries. This meant that if a person's situation changed (e.g., financially) in a way that would normally disqualify them from the program, Iowa Medicaid was required to maintain coverage for the person during the PHE. On Dec. 29, 2022, President Biden signed the Consolidated Appropriations Act of 2023 that ended the Medicaid program's continuous coverage requirement as of April 1, 2023. This means that most Medicaid members will go through a redetermination process during the 12-month unwinding period to determine if they are still eligible for any Medicaid program(s). This includes individuals who have not had a redetermination in the last 12 months and those who have been deemed ineligible but whose coverage is being maintained. If you are able to view Medicaid eligibility through DHHS' Iowa Medicaid Portal Access (IMPA) system, make sure you are watching your residents' eligibility closely to ensure they are covered. Remain in close contact with the individuals in charge of returning the Medicaid review paperwork as your Medicaid recipients come due for an eligibility review. Learn more at the Iowa HHS Medicaid CCR Unwind website.