Coronavirus Disease 2019 (COVID-19) Frequently Asked Questions (FAQs) for Non Long-Term Care Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IIDs)
June 2020

The Centers for Medicare & Medicaid Services (CMS) continually strives to provide timely and actionable guidance to State Survey Agencies and non long-term care providers and suppliers as the health care system confronts the COVID-19 Public Health Emergency (PHE). CMS has released several resources and guidelines and established numerous flexibilities to help prevent and control the transmission of COVID-19. Since the issuance of these materials, we have received requests to provide clarifying information. The purpose of this FAQs document is to clarify existing guidance and flexibilities and provide stakeholders with additional information based on questions received regarding the following entities:

- Ambulatory Surgical Centers (ASCs)
- Hospitals & Critical Access Hospitals (CAHs)
- Hospice
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
- Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs)

It is incumbent upon providers and suppliers to comply with Medicare and Medicaid's essential health and safety standards to keep Americans safe. It is also the responsibility of each entity to work with individual patients and residents, along with their families, caregivers, health care providers, and suppliers to support decisions that are best for each patient or resident.

General Questions

1. **Question: Where can Medicare/Medicaid certified providers and suppliers find current information on CMS guidance and flexibilities?**

Answer: CMS strongly urges Medicare/Medicaid certified providers and suppliers to monitor the COVID-19 Centers for Disease Control and Prevention (CDC) website, as well as their State, territorial and local public health website, and follow recommended guidelines and acceptable standards of practice. Recently issued CMS policy guidance and survey and certification guidance is available for State Survey Agencies and Accrediting Organizations on the CMS current emergencies website. In addition, providers can sign up to receive emails of CMS press releases.

We recommend monitoring the Coronavirus Waivers and Flexibilities website for modifications in guidance to ease burden and assist providers in the delivery of healthcare. The webpage contains provider-specific fact sheets on new waivers and flexibilities, provider enrollment relief, and billing information on new waivers and flexibilities.

Additionally, CMS has broadened access to Medicare telehealth services and communication technology-based services so that beneficiaries can receive a wider range of services from their doctors and other clinicians without having to travel to a healthcare facility during the public

health emergency period. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. For more information on telehealth guidance, please see the following:

CMS Current Emergencies page—https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

CMS COVID-19 FAQs on Medicare Fee-for-Service (FFS) Billing—https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

2. **Question: What does it mean for my facility's COVID-19 response actions to be "not inconsistent with the state's emergency preparedness or pandemic plan?"**

Answer: The Trump Administration issued an unprecedented array of temporary regulatory waivers and rules to equip the American healthcare system with maximum flexibility to respond to the COVID-19 PHE. These temporary measures will help the healthcare system deal with potential surges by providing tools and support to create non-traditional care sites and quickly staff up if necessary. As each State may have different needs related to COVID-19, they also may have different plans and requirements to support their response efforts. Therefore, the flexibilities that CMS has granted on a national level may not always be consistent with the plans individual states have in place to address their specific needs. Therefore, in the application of any waiver, CMS expects providers to receive the corresponding approvals from the State on issues, such as licensure, and engage and coordinate with their State, territorial, and local health departments when deciding how to meet potential surge needs in their community that are "not inconsistent with the state's emergency preparedness or pandemic plan."

3. **Question: How do I coordinate with officials in my state regarding the state's emergency preparedness or pandemic plan?**

Answer: As part of the Medicare emergency preparedness requirements, participating providers and certified suppliers must establish and maintain a comprehensive emergency preparedness program, which includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials in order to maintain an integrated response during a disaster or emergency situation Therefore, we would expect facilities to ensure that their emergency preparedness response efforts are coordinated with their state officials by contacting the applicable State Survey Agency (SA) for guidance or assistance via this link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/ContactInformation.

4. **Question: Will certified Medicare/Medicaid providers and suppliers be cited for non-compliance if their state implements actions due to the COVID-19 PHE pursuant to state law that are in conflict with CMS requirements?**

Answer: Non-waived CMS requirements must be met at all times. We recognize that some states may issue orders, pursuant to their authorities (particularly public health orders) that might

conflict with our rules as they existed before the Secretary's declaration of the COVID-19 PHE (e.g., a ban on all visitation in inpatient facilities through a governor's executive order). CMS has already waived a great number of rules, including the visitation rights CoP for inpatient facilities (see, e.g., 42 C.F.R. 482.13(h)). A full list of waived provisions for providers can be found at: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf. Although we believe that we have addressed all potential situations in which our rules might conflict with state public health activities, if a provider encounters a situation in which a state's law or executive order conflicts with a non-waived CoP, they should contact their CMS Location for further instruction. If the state relaxes actions pursuant to their authorities, the CMS requirements in place for that period of time must be followed. Once the PHE ends, providers and suppliers must resume adherence to previously applicable Federal requirements.

5. **Question: Will certified Medicare/Medicaid providers and suppliers be cited for non-compliance during the COVID-19 PHE for not having appropriate PPE or supplies?**

Answer: Providers and suppliers should be taking actions to mitigate resource shortages and demonstrate that they are taking all appropriate steps to obtain the necessary supplies as soon as possible. However, given supply shortages during the COVID-19 PHE, State and Federal surveyors should not cite certified Medicare/Medicaid providers for not providing certain supplies (e.g., personal protective equipment (PPE) such as gowns, N95 respirators, surgical masks and alcohol-based hand rubs (ABHRs)) if they are having difficulty obtaining these supplies for reasons outside of their control during the PHE. CDC has guidance for strategies to optimize the supply of PPE to include contingency and crisis capacity strategies (e.g., considering the use of intact PPE beyond the manufacturer-designated shelf life for patient care activities). CMS recommends providers follow the CDC guidance to optimize the supply of PPE during the PHE. Once PPE becomes available or the PHE is lifted (whichever is earlier), providers should resume standard practices to meet applicable Federal requirements. Information on the shortage of surgical masks and gowns as well as emergency use authorizations for PPE can be found on the U.S. Food and Drug Administration (FDA) website at: https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/faqs-shortages-surgical-masks-and-gowns.

6. **Question: During the COVID-19 PHE, are we able to utilize expired products if we run out of non-expired products?**

Answer: The CDC has provided several resources to assist in optimizing the supply of PPE. CDC has guidance for strategies to optimize the supply of PPE to include contingency and crisis capacity strategies (e.g., considering the use of intact PPE beyond the manufacturer-designated shelf life for patient care activities). We recommend reviewing CDC guidance available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/healthcare-supply-ppe.html. Information on the shortage of surgical masks and gowns as well as emergency use authorizations for PPE can be found on the U.S. Food and Drug Administration (FDA) website at https://www.fda.gov/medical-devices/personal-protective-equipment-infection-control/faqs-shortages-surgical-masks-and-gowns.

Additionally, providers and suppliers experiencing a shortage should engage their local and state health and emergency management departments for assistance. To identify local health departments supporting preparedness and response activities, visit the website of the National Association for County and City Health Officials Directory of Local Health Departments.

7. **Question: If the COVID-19 PHE causes delivery delays or shortages of certain medications, how can our facility determine if medication expiration dates are extended?**

Answer: The U.S. Food and Drug Administration (FDA) monitors the supply chain for issues and lists medications with extended use dates in a searchable table, which can be accessed at the following link: https://www.fda.gov/drugs/drug-shortages/search-list-extended-use-dates-assist-drug-shortages.

Ambulatory Surgical Centers (ASCs)

8. **Question: My ambulatory surgical center (ASC) temporarily closed at the beginning of the COVID-19 PHE. Can my ASC now reopen and resume doing elective surgeries?**

Answer: ASCs are encouraged to work directly with their state, territorial, and local health departments to determine when to reopen and resume elective surgery. On April 19, 2020, CMS released recommendations for Re-opening Facilities to Provide Non-emergency Non-COVID-19 Healthcare: Phase I. CMS recognizes that at this time many areas have a low, or relatively low and stable incidence of COVID-19, and that it is important to be flexible and allow facilities to provide care for patients needing non-emergent, non-COVID-19 healthcare. In addition, as states and localities continue to stabilize, it is important to restart care that is currently being postponed, including surgeries and other procedures. Therefore, if states or regions have passed the Gating Criteria (symptoms, cases, and hospitals) announced on April 16, 2020, then they should proceed to Phase I, which allows for outpatient elective surgery. The White House Guidelines for Opening Up America Again can be found at the following link: https://www.whitehouse.gov/openingamerica/#criteria.

9. **Question: How can ASCs address the needs of patients in surge areas who may need hospital or ambulatory care during the COVID-19 PHE?**

Answer: CMS expects ASCs to coordinate with their state, territorial, and local health departments and their local healthcare systems operating under their state's emergency preparedness or pandemic plan during the COVID-19 PHE to help meet surge needs in their community. There are several options to address such needs, including:

- Close temporarily to preserve personal protective equipment (PPE), beds, ventilators, and other critical resources as applicable;
- Continue to operate as a Medicare-certified ASC providing services as the state allows;
- Furnish inpatient services under arrangement with a hospital;

- Become provider-based to a hospital for outpatient services; or
- Choose to enroll as a hospital itself to provide hospital services.

Each option must be carefully considered by the ASC and should not be inconsistent with its state's plan. As part of the CMS's Hospitals Without Walls initiative, for the duration of the COVID-19 PHE, hospitals may contract with local ASCs to provide inpatient or outpatient services under the existing hospital CMS Certification Number (CCN) for care furnished during the PHE. ASCs that partner with a local hospital would no longer be functioning as a certified-ASC and would be under the control of the hospital.

If an ASC enrolls as a hospital on its own, the ASC would no longer be functioning as a certified ASC; and must meet the hospital Conditions of Participation, to the extent not waived; and must intend to provide hospital inpatient or outpatient services, provided that it operates in a manner not inconsistent with the State's emergency preparedness or pandemic plan (for example, as a COVID-19 treatment site). The ASC would be functioning as a full hospital, not solely as a hospital outpatient surgical department.

Additional FAQs related to billing may be accessed at the following link:
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

10. **Question: How do I make the change from a Medicare-certified ASC to temporarily enrolling as a hospital?**

Answer: Prior to seeking participation in Medicare as a hospital during the PHE, ASCs should contact their State health department and SA to determine their role in their state during the PHE. While CMS has created flexibilities to allow enrolled ASCs to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity, not all States are permitting ASCs to operate in this way, and ASC's must continue to follow all State laws and regulations. Interested ASCs may use the provider enrollment hotline to contact the Medicare Administrative Contractor serving their jurisdiction (contact information located at https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid19.pdf) to enroll as a hospital pursuant to a streamlined enrollment and survey and certification process. Temporary enrollment as a hospital may be pursued as long as (1) doing so is not inconsistent with the state's emergency preparedness or pandemic plan; (2) no Immediate Jeopardy (IJ)-level deficiencies were found within the previous three years for the ASC, or if IJ-level deficiencies were found but were subsequently removed through the normal survey process and no enforcement activities are currently ongoing; and (2) the relevant location meets the Conditions of Participation and other requirements not waived by CMS.

11. **Question: My ASC wishes to enroll temporarily as a hospital but cannot meet the hospital Conditions of Participation (CoPs). Can we submit a waiver request with our attestation to the MAC?**

Answer: No. QSO-20-24-ASC states that if an ASC enrolls as a hospital it must meet the hospital CoPs, to the extent not waived, and would receive hospital payments, not ASC payments. ASCs temporarily enrolling as hospitals are doing so with the intent to provide

expanded capacity and to treat patients during the COVID-19 PHE, which may include expanded services and a higher payment rate under the hospital payment system.

For the most up to date information on blanket waivers that are currently in effect for hospitals, please see the following: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf. ASCs temporarily enrolling as hospitals will not need to meet those CoPs currently waived for hospitals.

Additional blanket waiver requests may be submitted for consideration to CMS at 1135waiver@cms.hhs.gov however, individual emergency waivers will not be considered or processed through the attestation expedited enrollment process.

Hospitals and Critical Access Hospitals

12. Question: What are the options for hospitals with patients who no longer need acute-level care but need skilled-level care when the hospitals are unable to find placement for them in a skilled nursing facility (SNF)?

Answer: There are several options currently in place for hospitals unable to find placement for patients no longer needing acute-level care, but who need skilled nursing care:

a) CMS issued a section 1135 blanket waiver of the current "swing bed eligibility requirements" during the PHE. Hospitals are able to request swing bed service approval to provide this optional service of skilled nursing facility (SNF) level care in their facilities. The use of swing beds allows a hospital to use its beds interchangeably for either acute-care or post-acute care. A "swing-bed" is a change in payment status where the patient swings from receiving acute-care hospital inpatient services and payment to receiving post-acute care SNF services and payment. Hospitals with swing beds must comply with all other hospital conditions of participation including those special requirements for swing-bed providers set out at 42 CFR 482.58(b), to the extent not waived. Critical access hospitals (CAHs) with swing beds must comply with all other CAH conditions of participation including the special requirements for CAH providers of long-term care services set out at 42 CFR 485.645, to the extent not waived. For more information about the swing bed waiver, please refer to the CMS section 1135 waivers website at https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers. For additional information regarding swing bed services, please also see the CMS MLN Matters FAQs at https://www.cms.gov/files/document/se20018.pdf.

b) A hospital can also make arrangements with a skilled nursing facility to bring a separately certified SNF into the hospital under contract and facilitate the exchange of patients and information between the hospital and this separately certified SNF. According to the regulations at 42 CFR 483.70(j), there must be a transfer agreement in place to facilitate the exchange of patients and information between the hospital and SNF.

c) A hospital can apply for a distinct part SNF to be located within the hospital as a part of

the hospital in accordance with the regulation at 42 CFR 483.5. A distinct part SNF or NF may comprise one or more buildings or designated parts of buildings (that is, wings, wards, or floors) that are: in the same physical area immediately adjacent to the institution's main buildings; in other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and in any other areas that CMS determines on an individual basis, to be part of the institution's campus. The hospital would have the final responsibility for the distinct part's administrative decisions and personnel policies, and final approval for the distinct part's personnel actions, and must comply with the hospital CoPs. Unlike swing beds, beds in a distinct part SNF in a hospital must be in a defined, separate area as required at § 483.5, "A distinct part must include all of the beds within the designated area, and cannot consist of a random collection of individual rooms or beds that are scattered throughout the physical plant."

13. **Question: Does the waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay, pursuant to section 1812(f) of the Act, apply to swing-bed services furnished by hospitals and critical access hospitals (CAHs)?**

Answer: Yes, under the section 1812(f) waiver, hospitals and CAHs that have received approval to provide swing-bed services may furnish extended care services to a patient requiring SNF-level services even if the patient has not had a 3-day prior hospitalization in that or any other facility.

14. **Question: At a CAH, if swing bed patients are seen by a nurse practitioner (NP) at the time of admission, can they be the admitting provider? Does the physician still need to see the patient and if so, what is the required time frame?**

Answer: If mid-level practitioners admit patients (acute and/or swing-bed patients) to the CAH, a Doctor of Medicine/Doctor of Osteopathic Medicine (MD/DO) is responsible for any medical concern outside the scope of practice of the admitting practitioners. According to the Conditions of Participation (CoPs) at 42 CFR 485.631(b)(1), all acute and/or swing-bed inpatient records for patients whose treatment is/was managed by a non-physician practitioner in the CAH, i.e., nurse practitioners, clinical nurse specialists, or physician assistants, must be reviewed periodically by a CAH MD/DO who must sign the records after the review has been completed. The MD/DO review is expected to cover all applicable inpatient records open at the time of the review, as well as all applicable inpatient records closed since the last review. CAH CoPs do require countersignatures on all inpatient records. CAH bylaws, rules and regulations, and/or policies would address the time frames of those reviews, and MD/DO countersignatures.

The special requirements for CAH swing-bed patients state that a comprehensive care plan must be-- (i) developed within 7 days after the completion of the comprehensive assessment; (ii) prepared by an interdisciplinary team that includes the attending MD/DO, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's family or the resident's legal representative; and (iii) periodically reviewed and revised by a team of qualified persons after each assessment. The MD/DO must participate as part of the

interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-to-one discussions and conference calls.

Please refer to the CMS section 1135 waivers website for the most current flexibilities provided they are implemented consistent with the state's emergency preparedness or pandemic plan: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

15. **Question: If a hospital or Critical Access Hospital (CAH) expands its number of beds to 50 or more, will the provider-based Rural Health Clinics (RHCs) remain exempt from the per-visit payment cap due to provider-based payment requirements that have not been waived during the COVID-19 PHE?**

Answer: Due to the COVID-19 PHE, hospitals/CAHs may plan to increase inpatient bed capacity to address the surge in need for inpatient care. Therefore, for the duration of the COVID-19 PHE, CMS has implemented, via rulemaking, a change to the period of time used to determine the number of beds in a hospital or CAH, to utilize the methodology set out at 42 CFR 412.105(b), for purposes of determining which provider-based RHCs are subject to limit. During the PHE, we will use the number of beds from the cost reporting period prior to the start of the PHE as the official hospital bed count for application of this policy. RHCs with provider-based status that were exempt from the per-visit payment limit in the period prior to the effective date of the PHE, would continue to be exempt for the duration of the COVID-19 PHE. Allowing these provider-based RHCs to continue receiving the payment amounts they would otherwise receive in the absence of the PHE will help maintain their ability to provide necessary health care services to underserved communities.

Please see Section II.H of CMS's Interim Final Rule with Comment Period, "Medicare and Medicaid Programs; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency" (85 FR 27550, 27569), which can be found at: https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory.

16. **Question: Is it possible for an acute care hospital to contract with a Medicare-certified ASC to become a temporary outpatient surgical department of the hospital under the hospital's CMS Certification Number (CCN)?**

Answer: Yes. During the COVID-19 PHE, CMS is allowing hospitals to provide hospital outpatient services in temporary expansion sites, which may include ASCs, to help address the urgent need to expand their care capacity. Hospitals choosing to use certified-ASCs as temporary expansion locations should refer to the CMS Hospitals Without Walls guidance: https://www.cms.gov/files/document/covid-hospitals.pdf. and the COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing document as these provide detailed guidance related to payment and adding provider-based locations during the PHE.

17. **Question: Is it possible for a licensed independent freestanding emergency department (IFEDs) to participate in Medicare to assist with the hospital surge capacity during the COVID-19 PHE?**

Answer: Yes, during the COVID-19 PHE, CMS is allowing licensed IFEDs to participate in Medicare as a hospital on a temporary basis to help address the urgent need to expand hospital capacity in a manner that is not inconsistent with the state emergency and pandemic plan. Not all states are permitting IFEDs to operate this way. The IFED may choose to contract with a Medicare-certified hospital and deliver services as a hospital outpatient department or the IFED may choose to temporarily enroll in Medicare as a hospital through an attestation process. The IFED is responsible for compliance with all State licensure laws and regulations. For information about licensed IFED participation, see: https://www.cms.gov/files/document/qso-20-27-hospital.pdf

18. **Question: Would an IFED enrolling as a hospital be subject to compliance with all of the hospital Conditions of Participation (CoP)?**

Answer: Yes. A licensed IFED that temporarily enrolls in Medicare as a hospital would be required to meet all of the hospital CoPs, to the extent not waived by the blanket section 1135 waivers for Hospitals and CAHs. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-katwaivers.pdf .

19. **Question: Would an IFED temporarily enrolling as a hospital be permitted to submit an additional waiver request for a hospital CoP that cannot be met for compliance?**

Answer: It is expected that the attestation submitted at the time of request for temporary enrollment is confirming that the IFED meets the hospital CoPs to the extent not waived.

20. **Question: Do hospitals have to continue to report deaths from COVID-19 to Organ Procurement Organizations (OPOs) under the requirements at 42 CFR 482.45?**

Answer: Yes. Hospitals must notify in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. This requirement has not been waived. It is important to maintain this requirement because the cessation of collection of deaths from COVID-19 data to the OPO will have implications on the data used for monitoring OPO performance. It will skew the data collected on the OPO's donor potential and the overall impact of COVID-19 on donation. In addition, we do not know the impact on not reporting these deaths might have an impact on eye and tissue donation, which is under the purview of the FDA, but is often completed by Medicare-certified OPOs.

Hospice

Note: *Language in red italics represents revisions to previously published FAQs from the QSO 20-16-Hospice memorandum. https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/guidance-infection-control-and-prevention-*

concerning-coronavirus-disease-2019-covid-19-hospice

21. Question: How should hospices screen patients for COVID-19 when the patient needs short-term inpatient care at a hospice inpatient facility?

Answer: Hospices should identify patients at risk for having COVID-19 infection before or immediately upon arrival to the hospice inpatient facility. Guidance for evaluating and testing patients for COVID-19 infection can be found on the CDC website at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html.

22. Question: How should hospice programs monitor or restrict health care staff or hospice volunteers?

Answer: Please refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel or volunteers from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Hospices should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

Hospices making decisions about return to work for their healthcare professionals with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection such as cough, sore throat, shortness of breath, or fever but did not get tested for COVID-19) should be made according to the CDC guidelines available at https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html.

Strategies for optimizing PPE upon return to work for hospice health care personnel (HCPs) who had confirmed or suspected COVID-19 can be located on the CDC website at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

23. Question: When is it safe to discontinue Transmission-based Precautions *for* inpatient hospice patients with COVID-19 or in-home isolation for in home hospice patients with COVID-19?

Answer: The decision to discontinue Transmission-Based Precautions for inpatient hospice patients with COVID-19 should be made *in accordance with the CDC guidelines available at https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html.*

The decision to discontinue in-home isolation for in home hospice patients with COVID-19 should be made in the context of local circumstances.

For more information, see https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home- patients.html.

24. Question: What Personal Protective Equipment (PPE) should hospice staff

routinely use when visiting the home of a patient with suspected or confirmed COVID-19 exposure?

Answer: If care provided to patients who are confirmed or suspected to be COVID-19 positive is anticipated, then Hospice Agencies should refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

Hospices experiencing a shortage of PPE should engage their local and state health and emergency management departments for assistance. To identify local health departments supporting preparedness and response activities, visit the National Association for County and City Health Officials Directory of Local Health Departments at https://www.naccho.org/membership/lhd-directory.

25. **Question: Can an assisted living facility/independent living facility restrict hospice staff from caring for a hospice patient in their facility during this COVID-19 PHE?**

Answer: CMS does not regulate assisted living and independent living facilities. They do not participate in the Medicare or Medicaid programs. Hospice providers are encouraged to coordinate with assisted living/independent living facilities to assure that core services related to direct clinical care can be provided in an appropriate and safe manner.

Hospices serve an important role in providing **essential** healthcare services in a variety of community-based settings, including assisted and independent living facilities, and should be granted access as long as their staff meet the CDC guidelines for healthcare workers. If hospice staff are appropriately wearing PPE, and do not meet criteria for restricted access *based on CDC guidance,* they should be allowed to enter and provide services to the patient, *see https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html*. Additionally, hospice personnel should participate with any screening activity that the facility requires.

If access is restricted, hospices should communicate with the facility administration, including the State or local health department when indicated, on the nature of the restriction and timing for gaining access to hospice patients. Communication should also occur with the hospice patient's family or representative. This communication is essential for maintaining surveillance and preventing the spread of infection while also ensuring access of patients to essential services. *If after reasonable attempts have been made and documented in the patient's record and the hospice continues to be unable to access the patient in-person, the hospice would have to discharge the patient as "outside of the hospice's service area" (Medicare Benefit Policy Manual, chapter 9, 20.2.3): https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c09.pdf. Additionally, a hospice must forward to the patient's attending physician a copy of the hospice discharge summary and patient's clinical record if requested.*

Guidance provided for those with chronic and serious illness can be found

here: https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html.

Additionally, CDC provides the following recommendations for clinicians: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

26. Question: Previous guidance provided for hospice patients residing in nursing homes referenced "Compassionate Care" visits but many of our hospice providers who serve patients in this setting have been told they are not considered essential personnel and have been prevented from entering the facility. Can CMS provide any additional guidance?

Answer: CMS considers hospice workers providing specialized palliative and end-of-life care to be essential healthcare workers. Hospice staff should be permitted to come into a facility as long as they meet the CDC guidelines for health care workers. CMS has reinforced this guidance for nursing homes in our recent memoranda referenced below. CMS recognizes that hospice providers play an essential service in the care of those with terminal illnesses, and encourages providers to work collaboratively with facility staff to provide needed care in a safe and appropriate manner that is consistent with current CDC guidance for health care workers.

Guidance and FAQs related to nursing homes are available at https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf and https://www.cms.gov/files/document/qso-20-28-nh.pdf.

27. Question: What flexibilities are there for hospices during the COVID-19 PHE?

Answer: On March 30, 2020, CMS released the interim final rule with comment period, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" (85 FR 19230). Pursuant to section II.H of that interim final rule, (85 FR 19250), CMS is expanding access to telehealth services for people with Medicare during the COVID-19 PHE. For more information, consult the Interim Final Rule document at the Coronavirus Waivers & Flexibilities website: https://www.cms.gov/files/document/covid-final-ifc.pdf.

CMS has also announced the release of several blanket waivers intended to provide flexibilities for hospices during the public health emergency for COVID-19. Individual waiver requests will be reviewed by CMS on a case by case basis. CMS continues to update the blanket waivers. We recommend monitoring the website for updates at https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

28. Question: Where can I find questions and answers on the use of telehealth in hospice care?

Answer: For more information on the hospice care, see https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf, describing policies

allowing for use of telehealth or telecommunications technology in furnishing hospice care during the COVID-19 PHE.

29. **Question: Given the current COVID-19 PHE, we have challenges with providing core services due to staff shortages and illness. Will CMS consider waivers to utilize contracted staff to address these gaps during the PHE?**

Answer: CMS currently allows for use of contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. Furthermore, a hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients as described under 42 CFR 418.64, "Condition of participation: Core services." Therefore, no waiver is required to use contracted services for this purpose.

30. **Question: Given the current COVID-19 PHE, we are concerned with having enough PPE to provide volunteers given current shortages and concern for potential exposure. Additionally, we have heard some patients are not allowing any visits and our providers are concerned about meeting the 5% of patient care hours for volunteers during the PHE.**

Answer: CMS recognizes that volunteer services represent an essential component of the current hospice benefit and provide invaluable services to the patients. Given the current PHE, CMS is waiving the requirement that hospices be required to use volunteers (including at least 5% of patient care hours). Alternatively, hospice providers may continue to utilize volunteers in other non-direct care activities (e.g. administration activities) and consider using the flexibilities allowing for use of telecommunications technologies to further facilitate ways in which volunteers can continue to support the patients served, however, this is not required during the COVID-19 PHE.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

31. **Question: How should an ICF handle the discharge summary when a client is admitted on a temporary emergency basis from the community or another ICF?**

Answer: Regulations regarding ICF/IID discharge have not been waived. A discharge, even on a temporary emergency basis, requires that key developmental, behavioral, social, health and nutritional information be shared with the accepting facility in the community or non-facility provider. CMS is aware that staffing shortages and/or client surges due to the PHE create a high demand on available staff time that makes it difficult to complete a full discharge summary for each client. Each ICF will need to evaluate what amount and detail of documentation is necessary to ensure that critical health information is shared with the accepting facility or other provider. When available and if appropriate, the Interdisciplinary Team (IDT) should maximize the use of telehealth for the completion of a client's discharge plan during the PHE.

Consistent with their wishes and their person-centered plans, clients should be discharged to the most integrated setting appropriate. The integration mandate of the Americans with Disabilities Act requires facilities to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.[1]

32. Question: How should an ICF handle the development of a Comprehensive Functional Assessment (CFA) and an Individual Program Plan (IPP) when a client is admitted on a temporary emergency basis from the community or another ICF?

Answer: Clients who are admitted on a temporary emergency basis to an ICF during the PHE will nonetheless continue to need to have a Comprehensive Functional Assessment (CFA) and an Individual Program Plan (IPP) in accordance with 42 CFR 483.440(c). Completion of these documents will provide an opportunity for the IDT and staff to meet the basic and critical care needs of the client. CMS is aware that staffing shortages and/or client surges due to the PHE may create a high demand on available staff time that makes it difficult to complete a full CFA and IPP. Each ICF will need to evaluate what amount and detail of documentation is necessary to ensure that critical health and treatment information is identified to allow active treatment during the PHE. This health and treatment information will support successful adjustment for the client to the new temporary living environment. When available and if appropriate, the IDT should maximize the use of telehealth for the development of a client's IPP for temporary emergency admissions during the PHE.

33. Question: During the PHE are ICFs still required to have and use a specially constituted committee or committees?

Answer: Yes. CMS believes that the use of this committee may be of value during the time of the COVID-19 PHE. The committee can provide an opportunity to support and make suggestions to facilities as they may need to adapt policies and procedures as well as why and how services are being provided to clients, which clients may find difficult to understand and potentially lead to inappropriate adaptive behavior. When available and if appropriate, the specially constituted committee should maximize the use of telecommunications to convene this committee as a resource to support the challenges faced by staff and clients during the PHE.

34. Question: When a client has tested positive for COVID-19 and the ICF/IID implements quarantine procedures, client rights are immediately abridged and severe behaviors are likely to occur. What is the guidance from CMS on balancing the CDC expectations with the rights of the individual?

[1] Please note that consistent with the integration mandate of Title II of the ADA and the *Olmstead vs LC*, [527 U.S. 581 (1999)], decision, facilities are obligated to offer and provide discharge planning, case management, and transition services, as appropriate, to individuals who are removed from their Medicaid home and community based services under these authorities during the course of the public health emergency, as well as to individuals with disabilities who may require these services in order to avoid unjustified institutionalization or segregation. Transition services, case management, and discharge planning should be provided to facilitate these individuals in their return to the community when their condition and public health circumstances permit, consistent with an individual's wishes and person-centered plan.

Answer: The health and safety of the clients, visitors, and staff at an ICF/IID are of the utmost importance for CMS. Based on the ICF Emergency Preparedness plan, and in accordance with the requirement at 42 CFR 483.440(c)(3)(v) that the IPP assess the client's health status in the context of a COVID-19 diagnosis, the ICF/IID must revise the client's IPP to reflect specific procedures and steps that will be taken to quarantine the client while also taking every step reasonable to protect the rights, safety, and health of the infected client, as well as those of the staff and other clients. ICF/IIDs are encouraged to use telehealth and assistive technology to minimize social isolation to the extent possible.

35. Question: Are intermediate Care Facilities required to participate in the COVID-19 CDC National Healthcare Safety Network (NHSN) reporting requirements?

Answer: ICF/IIDs **do not** have a regulatory requirement for the reporting of communicable diseases, healthcare-associated infections, and potential outbreaks to Federal (such as the CDC), State and/or local health departments. ICF/IIDs **do have** a requirement under 42 CFR 483.420(c)(6), which addresses communication to family and/or guardian when a client's condition changes, including the onset of serious illness (such as COVID-19).

Although reporting to CDC is not required, ICF/IIDs may voluntarily report COVID-19 cases to the CDC, and CMS encourages them to do so to facilitate public health tracking of the pandemic. You may find the following CDC resource links helpful:
https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/covid19-enrollment-508.pdf and
https://www.cdc.gov/nhsn/pdfs/covid19/ltcf/cms-covid19-req-508.pdf.

Rural Health Clinics (RHC)/Federally Qualified Health Centers (FQHCs)

36. Question: Has CMS implemented any flexibilities to help RHCs and FQHCs respond to the PHE posed by COVID-19?

Answer: Yes. CMS has temporarily waived certain regulatory requirements providing flexibilities to assist RHCs and FQHCs in furnishing services during the COVID-19 PHE. This includes temporarily modifying the following:

(a) 50% mid-level staffing requirement for RHCs;
(b) Physician supervision requirement for nurse practitioners (NPs), to the extent permitted by State law; and
(c) Location requirements for existing RHCs and FQHC to allow additions of temporary service locations.

Please see https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf for additional waiver information. Additional flexibilities, including guidance for RHCs and FQHCs furnishing telehealth services during the PHE, are also described in this CMS MLN Article: https://www.cms.gov/files/document/se20016.pdf

37. Question: When do these flexibilities go into effect?

Answer: The flexibilities for staffing requirements, physician supervision of nurse practitioners, and temporary expansion sites are retroactively effective beginning March 1, 2020, through the end of the emergency declaration and CMS issues an end of outbreak notification.

38. Question: Do these flexibilities apply to all RHCs and FQHCs?

Answer: The flexibilities for physician supervision of NPs apply to all RHCs and FQHCs, to the extent permitted by state law. Flexibilities to the 50% mid-level staffing requirement apply to RHCs only as the mid-level requirement is RHC specific. Lastly, flexibilities to the location requirement apply to existing RHCs and FQHCs.

39. Question: How does the mid-level practitioner 50% flexibility benefit an RHC? Are RHCs required to submit any documentation to CMS for this waiver?

Answer: This waiver provides RHCs with flexibilities with regards to the percentage of operating hours the facility has a mid-level practitioner available to furnish patient care services. While the waiver offers flexibilities with staffing mixes, a physician, NP, physician assistant, certified nurse midwife, clinical social worker, or clinical psychologist must be available on site to furnish patient care services whenever the RHC is open and operating. CMS does not require any submission of documentation for this waiver.

40. Question: How does the waiver affect the physician supervision of NPs?

Answer: During the PHE, NPs may function to the fullest extent possible without physician supervision, and to the extent of applicable state law. However, the physician continues to be responsible for providing the overall medical direction for the RHC/FQHC's health care activities, consultation for, and medical supervision of all other health care staff, either in person or through telehealth and other remote communications.

41. Question: Can an RHC/FQHC provide patient care services at temporary locations?

Answer: Yes. During the COVID-19 PHE, CMS is allowing currently approved RHCs/FQHCs to provide patient care services in temporary expansion sites to help address the urgent need for supplementary care. These temporary sites are not restricted to the rural/shortage area location requirements. Each location is obligated to follow RHC/FQHC regulations to the extent not waived. Therefore, the RHC/FQHC may provide services provided at a temporary location under the CMS Certification Number (CCN) for the permanent location. The RHC/FQHC is expected to be operating in a manner not inconsistent with its state's emergency preparedness plan. Note: FQHCs must also have an updated Health Resource and Service Administration (HRSA) Notice of Award, expanding the scope of service to include the temporary location(s) to support response to the COVID-19 PHE.

42. Question: Do these flexibilities apply to temporary locations established in a parking lot?

Answer: Yes. During the COVID-19 PHE, CMS is allowing RHC/FQHCs to establish temporary expansion sites in a parking lot; either on or off its premises. As with other temporary expansion locations, the parking lot site must meet the same RHC/FQHC regulations as the main site, unless otherwise waived. Therefore, the RHC/FQHC may provide for those services via the existing CCN of its approved permanent location. RHC/FQHC is expected to be operating in a manner not inconsistent with its state's emergency preparedness plan.

43. Question: Can an RHC/FQHC provide patient care services to a patient in the patient's vehicle?

Response: During the COVID-19 PHE, to help minimize transmission, an RHC/FQHC visit can take place if the patient is in a vehicle on the premises of the RHC/FQHC and all requirements for a billable visit are met (e.g. medically-necessary, face-to-face visits with an RHC/FQHC practitioner). The RHC/FQHC would provide the services using its existing CCN. All services provided are held to all RHC/FQHC regulations, unless otherwise waived. This includes, but is not limited to, the provisions of services as per 42 CFR 491.9(c). RHCs/FQHCs must consider the clinical appropriateness of services before conducting a visit and/or treating a patient in their vehicle.

44. Question: Will a RHC or FQHC seeking approval of its temporary location as being consistent with the emergency response and pandemic plan be provided with evidence of approval or denial from the state?

Answer: State emergency plans and processes will vary. RHCs/FQHCs should retain any communications with the State emergency preparedness representatives to demonstrate that its temporary location(s) are not inconsistent with the state emergency preparedness and pandemic plan for the COVID-19 PHE. Once the state has approved the addition of temporary location(s), there are no additional CMS enrollment or reporting requirements. The RHC/FQHC may begin utilizing the temporary expansion location throughout the duration of the COVID-19 PHE.

45. Question: May an RHC or FQHC continue providing RHC/FQHC services at the temporary location once the COVID-19 PHE ends?

Answer: No. All waived CoPs, CfCs, requirements, and most temporarily revised regulations will terminate at the end of the PHE. If the RHC/FQHC wishes to continue services at the temporary expansion location after the PHE has ended, the facility must submit form 855A to begin the process of enrollment and initial certification as a RHC or FQHC under the regular process and meet all applicable requirements, including 42 CFR 491.5.

46. Question: My RHC participates in Medicare through one of the two CMS-approved RHC Accreditation Organizations (AOs). Do waivers of CMS regulations apply to CMS-approved accrediting programs? Do I need to notify the AO of my desire to temporarily add a service location during the COVID-19 PHE?

Answer: The flexibilities apply to both accredited and non-accredited RHCs. Notifying your AO of the temporary location is recommended.

47. Question: Where can I find answers to COVID-19 flexibilities regarding Medicare Fee-for-Service (FFS) billing for RHCs and FQHCs?

Answer: To assist RHCs and FQHCs in furnishing service during the COVID-19 PHE, CMS has provided additional flexibilities related to billing for services. These temporary flexibilities currently include Expansion of Virtual Communication Services for RHCs and FQHCs to include online digital evaluation and management services using patient portals, and Revision of Home Health Agency Shortage Area Requirement for Visiting Nursing Services Furnished by RHCs and FQHCs. Please see the Medicare FFS Billing FAQ document available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

Please see Section II.L of the Interim Final Rule with Comment Period, "Medicare and Expanded Flexibilities for Rural Health Clinics (RHCs) Medicaid Programs; Policy and Federally Qualified Health Centers (FQHCs) During Regulatory Revisions in Response to the COVID-–19 Public Health Emergency (PHE)"

(85 FR 19230, 19253), available at https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public, for more information on regulatory changes for RHCs and FQHCs.