The Public Health Emergency Has Ended

Breaking Down the Guidance for Long Term Care Facilities, Home Health and Hospice

Jean Storm DO, CMD
Medical Director, Quality Insights

1973-2023 50 years
Quality Insights

Continuing Education

- To complete the course, the learner must:
  - Watch the 45-minute webinar (live or recorded)
  - Complete the evaluation & pass the post-knowledge check
  - Contact hours approved for Nursing
    - Quality Insights is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation
- Jean Storm, DO, CMD and other planners for this educational activity have NO relevant financial relationships with ineligible companies to disclose.
- Expiration for this enduring material is 06/27/2026

Objectives

At the conclusion of this webinar the attendee will be able to:

- Identify the changes that all providers across all healthcare environments must make with the ending of the public health emergency.
- Explain the procedures for long term care facilities need to put into place now regarding COVID-19 infection reporting, vaccination reporting, vaccination education, and testing.
- State the compliance timelines for the changes from the ending of the public health emergency.

3 Years and 100 Days Later…

As Covid Emergency Ends, U.S. Response Shifts to Peacetime Mode

The coronavirus public health emergency, declared by the Trump administration in 2020, will expire on Thursday. Interviews with senior health officials suggest the nation is not ready for a new pandemic.

Give this article 269

Stolberg, Sheryl Gay and Weiland, Noah. “As Covid Emergency Ends, US Response Shifts to Peacetime Mode.” New York Times. May 10, 2023.

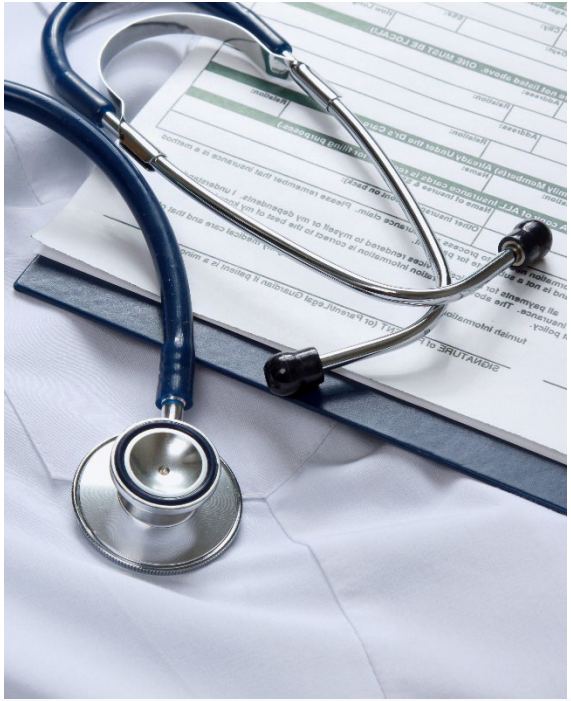
Public Health Emergency

- On January 31, 2020 the Secretary of the Department of Health and Human Services (HHS), Alex Azar, declared the 2019 Novel Coronavirus (2019-nCoV) outbreak a public health emergency.
- The Secretary of the Department of Health and Human Services (HHS) may, under section 319 of the Public Health Service (PHS) Act, determine that: a) a disease or disorder presents a public health emergency (PHE); or b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.

https://aspr.hhs.gov/legal/PHE/Pages/Public-Health-Emergency-Declaration.aspx

Waivers and Regulations

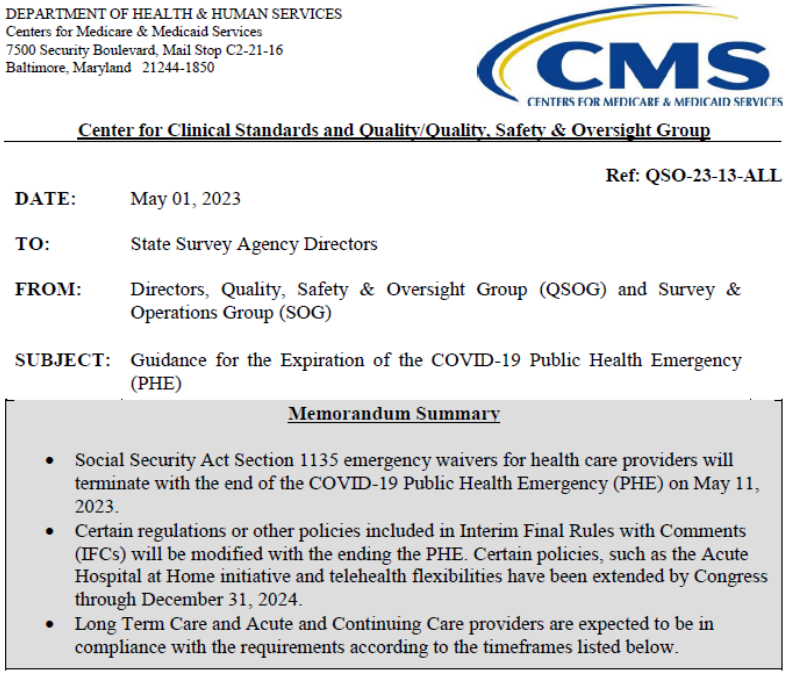
- Some changes during the PHE involved more regulations (vaccine mandate)
- Most of the changes made as a result of the PHE resulted in a “relaxation” or temporary suspension of regulations required by CMS
- These waivers allowed providers and facilities to focus on issues surrounding the pandemic



Important Note

- CMS has issued waivers that have terminated already (prior to the ending of the public health emergency on May 11, 2023).
- For a listing of all long term care waivers and dates of termination: https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf

The PHE Ended May 11, 2023



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-13-ALL

DATE: May 01, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE)

Memorandum Summary

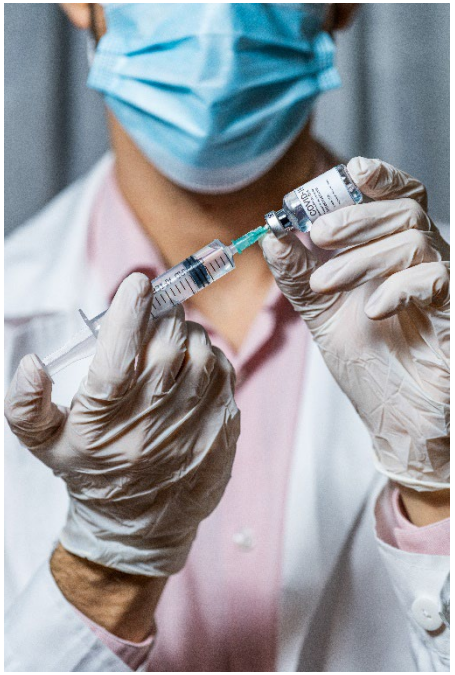
- Social Security Act Section 1135 emergency waivers for health care providers will terminate with the end of the COVID-19 Public Health Emergency (PHE) on May 11, 2023.
- Certain regulations or other policies included in Interim Final Rules with Comments (IFCs) will be modified with the ending the PHE. Certain policies, such as the Acute Hospital at Home initiative and telehealth flexibilities have been extended by Congress through December 31, 2024.
- Long Term Care and Acute and Continuing Care providers are expected to be in compliance with the requirements according to the timeframes listed below.

https://www.cms.gov/files/document/qso-23-13-all.pdf

Guidance for All Providers and Environments (1/2)

Vaccination requirements:

- On November 5, 2021, CMS issued an interim final rule requiring Medicare and Medicaid-certified providers and suppliers to ensure that their staff were fully vaccinated for COVID-19.
- CMS will “soon end this requirement”, but more details to come…(will “share more details regarding ending this requirement at the anticipated end of the public health emergency.”)



Guidance for All Providers and Environments (2/2)

Emergency Preparedness Training and Testing: during or after an actual emergency (PHE), the EP regulations allow for a one-year exemption from the requirement that the provider/supplier perform testing exercises.

- Inpatient providers and suppliers: must conduct a full-scale exercise within its annual cycle for 2023 and an exercise of choice
- Outpatient providers: must conduct either a full-scale exercise or an exercise of choice within its annual cycle for 2023, if scheduled to conduct the full-scale exercise within 2023. The provider/supplier must conduct the exercise of choice, if scheduled during the annual cycle for 2023 and resume the full-scale exercise requirement in 2024.

Testing Exercises

- Full-Scale Exercise (FSE): A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e. "boots on the ground" response activities (for example, hospital staff treating mock patients).
- Exercise of Choice: Mock Disaster Drill, Table-top Exercise, Workshop

Ref: QSO-20-41-ALL-Revised, https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdf

Long Term Care Facilities

3-Day Prior Hospitalization

- During the PHE, CMS waived the Medicare Part A SNF coverage requirement that a Medicare beneficiary must have a 3-day qualifying hospital stay to qualify for a covered Part A SNF stay
- All new SNF stays beginning on or after May 12, 2023, will require a 3-day qualifying hospital stay before Medicare coverage
- In addition, for any new benefit period that begins on or after May 12, 2023, the beneficiary will need to have completed a 60-day wellness period (a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF which begins on day of discharge).

Alcohol Based Hand Rub Dispensers

- During the PHE: CMS waived the requirement for ABHR dispensers for SNF/NFs at 42 CFR 483.90(a) during the PHE because of the need for the sudden increased use by staff and others off hand sanitizer.
- After the PHE: 42 CFR 483.90(a) in effect: A long-term care facility may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483

Preadmission Screening and Annual Resident Review

- During the PHE: CMS allowed nursing homes to admit new residents who did not receive Level I or Level II Preadmission Screening
- After the PHE: all providers are expected to be in compliance with the requirements for PASRR with all admissions taking place after May 11, 2023. The medical record for residents with a mental illness (MI) or intellectual disability (ID) must include evidence that PASRR Level I pre-screening is completed prior to admission and if the Level I pre-screening is positive, Level II screening is conducted prior to admission to the facility.

Resident Roommates and Grouping

- During the PHE: CMS waived 42 CFR 483.10(e)(5) and (7) requirements
- After the PHE: The resident has a right to be treated with respect and dignity, including:
  - ✓ The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.
  - ✓ The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:
    - (i) To relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or
    - (ii) To relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.
    - (iii) Solely for the convenience of staff.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483

Resident Transfer and Discharge

- During the PHE: CMS waived requirements in 42 CFR 483.10(c)(5)
- After the PHE: the facility must provide advance notification of options relating to the transfer/discharge to another facility and the written notice of transfer or discharge is to be provided before the transfer or discharge. This notice must be provided as soon as practicable (with some exceptions).

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483

Nurse Aide Training Competency and Evaluation Programs (NATCEP)

- During PHE: CMS waived the requirements which require that a SNF may not employ anyone for longer than four months unless they met the training and certification requirements
- After PHE: Uncertified nurse aides working in a LTC facility covered by a waiver granted to a State or individual facility will have 4 months from the date the PHE ends (or from the termination date of the facility's or state's waiver, if earlier) to complete a state approved NATCEP program. This includes those LTC care facilities, or facilities in states that were granted an extension of the waiver after October 6, 2022.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.35#p-483.35(d)

COVID-19 Guidance

CMS Core Principles of COVID-19 Infection Prevention (1/3)

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control)

  https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

CMS Core Principles of COVID-19 Infection Prevention (2/3)

- Hand hygiene (alcohol based hand rub)
- Face covering or mask (covering mouth and nose) in accordance with CDC: (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)

CMS Core Principles of COVID-19 Infection Prevention (3/3)

- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of PPE
- Effective cohorting of residents
- Resident and staff testing conducted as required at 42 CFR § 483.80(h): https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.80#p-483.80(h)

Face Coverings

- Source control refers to use of respirators or well-fitting facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. People, particularly those at high risk for severe illness, should wear the most protective mask or respirator they can that fits well and that they will wear consistently.
- Even when a facility does not require masking for source control, it should allow individuals to use a mask or respirator based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease if they are exposed.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Source Control Recommendations

Recommended for individuals who:

- Have suspected or confirmed COVID infection or other respiratory infection (e.g., those with runny nose, cough, sneeze)
- Had close contact (residents and visitors) or a higher-risk exposure with someone with COVID infection, for 10 days after their exposure

Source Control Recommendations

Recommended in facilities:

- By those residing or working on a unit or area of the facility experiencing a COVID or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of COVID infection have been identified for 14 days)
- Facility-wide or, based on a facility risk assessment, targeted toward higher risk areas or patient populations (e.g., when caring for residents with moderate to severe immunocompromised) during periods of higher levels of community COVID or other respiratory virus transmission
- Have otherwise had source control recommended by public health authorities

Standard Precautions

If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), healthcare personnel should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Reporting COVID-19

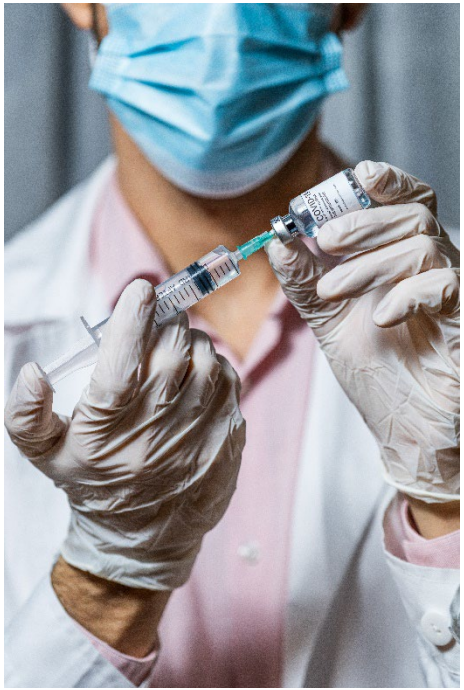
- During PHE: All LTC facilities are required to report COVID-19 information using the Center for Disease Control (CDC) National Healthcare Safety Network (NHSN). Additionally, facilities are required to inform the residents, their representatives and families following the occurrence of either a single confirmed infection of COVID-19 or three or more residents or staff with new-onset of symptoms.
- After PHE: All of the above is required EXCEPT:

  Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID–19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. “CMS is exercising enforcement discretion.”

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483#p-483.80(g)(3)

COVID Vaccination Reporting

- During PHE: facilities are required to report the COVID-19 vaccination status of residents and staff through NHSN
- After PHE: facilities are required to report the COVID-19 vaccination status of residents and staff through NHSN



COVID Vaccination Education

- During PHE: all LTC facilities are required to educate residents and staff on the COVID-19 vaccine and offer to help them get vaccinated.
- After PHE: this requirement will remain in effect until May 21, 2024, unless additional regulatory action is taken.

COVID Testing

- During PHE: LTC facilities are required to perform routine testing of residents and staff for the COVID-19 infection
- After PHE: LTC facilities must conduct COVID-19 testing in accordance with accepted national standards, such as CDC recommendations. Noncompliance with this expectation will be cited at F-880 for failure to implement an effective Infection Prevention and Control Program.

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of vaccination status, with signs or symptoms must be tested.	Residents, regardless of vaccination status, with signs or symptoms must be tested.
Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts	Test all staff, regardless of vaccination status, that had a high-risk exposure with a COVID-19 positive individual.	Test all residents, regardless of vaccination status, that had close contact with a COVID-19 positive individual.
Newly identified COVID-19 positive staff or resident that is unable to identify close contacts	Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g. unit, floor, or other specific area(s) of the facility).	Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g. unit, floor, or other specific area(s) of the facility).
Routine testing	*Not generally recommended*	Not generally recommended

https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf

Infection Control Surveys

- During PHE: All States are required to conduct focused infection control surveys in 20% of their nursing homes in fiscal year 2023
- After PHE: All States are required to conduct focused infection control surveys in 20% of their nursing homes in fiscal year 2023. They are not required to conduct additional FIC surveys in fiscal year 2024.

Home Health Agencies

Initial Assessments/Discharge Planning

- During PHE: Medicare-covered initial assessments and determination of patients' homebound status can be done remotely or by record review, sharing discharge planning not required.
- After PHE:
  - Medicare-covered initial assessments and determination of patients' homebound status must be done by RN.
  - Detailed information regarding discharge planning must be provided to patients and their caregivers, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, (another) HHA, skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), and long-term care hospital (LTCH) quality measures and resource use measures.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.55#p-484.55(a)

Rehabilitation Skilled Professionals Performing the Initial and Comprehensive Assessment

- During PHE: CMS allowed any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care.
- After PHE: When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician or allowed practitioner who is responsible for the home health plan of care, the initial assessment visit may be made by the appropriate rehabilitation skilled professional. For Medicare patients, an occupational therapist may complete the initial assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility.

42 CFR § 484.55 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.55

Onsite Visits for HHA Aide Supervision

- During PHE: CMS waived the requirements for a nurse to conduct an onsite visit every two weeks.
- After PHE: CMS finalized the provision for aide supervision for patients receiving skilled care every 14 days to now allow for one virtual visit per 60-day episode per patient and only in rare circumstances. For patients receiving non-skilled care, the registered nurse must make an onsite, in person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs; semi-annually the nurse must make a supervisory direct observation visit for each patient to which the aide is providing services. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.80#p-484.80(h)

Clinical Records/OASIS Reporting

- During PHE: No timeline to provide a copy of medical record, OASIS transmission requirements modified.
- After PHE: HHAs must provide a patient a copy of their medical record at no cost during the next visit or within four business days (when requested by the patient), OASIS transmission requirements: 1) five-day completion for the comprehensive assessment; and 2) 30-day OASIS submission requirement.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-C/section-484.110#p-484.110(e)

Hospice

Comprehensive Assessments

- During PHE: CMS waived certain timeline requirements for updating comprehensive assessments.
- After PHE: The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

42 CFR §418.54 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.54

Hospice Aide Competency Testing

- During PHE: CMS waived the requirement that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient (pseudo-patients could be used).
- After PHE: CMS finalized the hospice aide requirements to allow the use of the pseudo-patient for conducting hospice aide competency evaluations. CMS also finalized the hospice aide supervision requirements to address situations when deficient practice is noted and remediation is needed related to both deficient and related skills.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76#p-418.76(c)(1)

Non-Core Services/QAPI

- During PHE: hospices not required to provide certain non-core hospice services, CMS modified requirements to narrow the scope of the QAPI program to concentrate on infection control issues.
- After PHE:
  - Hospices must provide certain non-core hospice services for physical therapy, occupational therapy, and speech language pathology
  - Hospice and HHA must develop, implement, evaluate, and maintain an effective, ongoing, hospice/HHA-wide, data-driven QAPI program process.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/section-418.58
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.65

Compliance Timelines Beyond May 12

July 11, 2023

- Hospices and HHAs are required to have a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist), make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) are required to ensure that each client receives a continuous active treatment program, which includes consistent implementation of a program of specialized and generic training, treatment, health services and related services.

September 30, 2023

A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

42 CFR §418.100(g)(3) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.100

December 31, 2023

- Home health agencies and hospices must assure that each aide receives 12 hours of in-service training in a 12-month period.
- Hospices must use volunteers (at least 5% of total patient care hours of all paid hospice employees).
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) must provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that Interfere with direct client care.
- RHCs/FQHCs are required to ensure that physicians provide medical direction for the clinics or centers health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners.

Resources

- CMS: https://www.cms.gov/files/document/qso-23-13-all.pdf
- CMS FAQs: https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf
- HHS: https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html#:~:text=Based%20on%20current%20COVID%2D19,day%20on%20May%2011%2C%202023
- CDC: https://www.cdc.gov/coronavirus/2019-ncov/your-health/end-of-phe.html
- White House: https://www.whitehouse.gov/briefing-room/statements-releases/2023/05/09/fact-sheet-actions-taken-by-the-biden-harris-administration-to-ensure-continued-covid-19-protections-and-surge-preparedness-after-public-health-emergency-transition/

Evaluation and Post-Knowledge Check

- **Evaluation:** https://tinyurl.com/endofpheltc

QR Code
Activate the camera on your smart phone and scan this QR code to link to the **evaluation**

Thank You!

Quality Insights 50 years 1973-2023

QIN–QIO
Quality Innovation Network -
Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

This material was prepared by Quality Insights, a Quality Innovation Network - Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication number 12SOW-QI-PCH-053123KS