

Nursing Home Weekly: Recap of LeadingAge Updates

August 28, 2020

CMS releases Interim Final Rule with Comments on staff testing, CLIA reporting. This afternoon CMS issued the [rule](#) it announced in July would be coming soon, mandating staff testing and CLIA reporting for nursing homes that test. Here is an [article](#) summarizing the highlights that will be important for LeadingAge members. Effective immediately, nursing homes that fail to comply with requirements to report COVID-19 data to CDC through NHSN will be subject to

- Citation at the scope of widespread and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (level “F”).
- Enforcement of a CMP of \$1,000 per noncompliance, and
- Increasing increments of \$500 per CMP for up to 12 instances of noncompliance.

As outlined previously in CMS guidance, nursing homes that fail to report on a weekly basis will receive a \$1,000 CMP that increases incrementally by \$500 for each subsequent missed week of reporting. This will cap at 12 weeks (\$6,500) due to pre-existing statutory caps.

New Infection Control Training. CMS announced a new infection control training available to nursing homes: “CMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management”. Read the announcement [here](#). This training is designed for both front-line staff and nursing home management, with separate training modules for each (5 for front-line staff, 10 for management). This self-paced training is available immediately on the [CMS Quality, Safety & Education portal](#) and certificates of completion will be available for each course completed. Additionally, subject matter experts from CMS and CDC will be available through bi-weekly webinars beginning this Thursday, August 27 and running through January 7. Members can register for these webinars [here](#). LeadingAge posted an [article](#) related to the new COVID-19 training. There is still no indication at this time that this training is linked to Provider Relief Funding.

New guidance on the new rule. CMS released [guidance](#) on the new interim final rule for nursing homes. The guidance relies heavily on CDC guidance, so certain parts of implementation will not be too different from what nursing homes are already doing. For example, CDC Testing Guidelines for Nursing Homes, Return-to-Work Criteria for Healthcare Personnel, and Discontinuation of Transmission-Based Precautions. Of course, the biggest requirement, testing staff according to county prevalence, will be challenging. This will include:

- Monthly testing in counties with less than 5% positivity
- Weekly testing in counties with 5-10% positivity
- Bi-weekly testing in counties with greater than 10% positivity

Positivity rates should be monitored every other week [here](#) (the data will be available beginning August 28). Nursing homes have the flexibility to choose whether this testing is conducted via point-of-care antigen tests or nucleic tests processed in an off-site lab (PCR testing), provided test results are returned within 48 hours. The guidance also spells out how to respond to residents and staff who refuse testing, and exactly what documentation is required for a multitude of circumstances (outbreaks, symptoms, testing residents, testing staff, refusals, lack of access to testing, etc.). The COVID-19 Focused Survey Tool has been updated to reflect these changes.

PPE updates. The CMS call included details about PPE distribution, especially N-95s

- **N95 distribution:** Because of increased production of N95s, will be shipping 1.5 million n95s to nursing homes who need them (based on those who indicated need through NHSN reporting). Shipments will start this Thursday through next week.
- **Additionally, 14 million masks will be diverted from the national stockpile, and sent to targeted markets.** Will be sent to the commercial market place, hospitals, nursing homes, first responders, trying to provide additional commercial volume for those facilities to purchase.
- It was noted that “We are fundamentally in a different place than we were back in March or April.” The country now has 120,000 ventilators ready to deploy. States now have 30-60 day supply on hand of PPE.

POC Testing. Also on the CMS call, Adm. Giroir reported that 5,593 nursing homes had already received antigen testing machines. By the end of September all nursing homes with CLIA waivers (about 14,800) will have the machines. He added that over two million test kits had also been shipped, enough to test each staff members at least twice and that nursing homes would be able to order additional tests (no details provided on that).

FDA recommendations for diagnostic tests for screening asymptomatic individuals for COVID-19. An [FDA FAQ](#) recommended that health care providers screening asymptomatic individuals should consider using a highly sensitive test, especially if rapid turnaround times are available. If highly sensitive tests aren’t available or turnaround times are slow, providers should use less sensitive point-of-care tests, even if they aren’t specifically authorized for this indication (commonly referred to as “off label”). “For congregate care settings, like nursing homes or similar settings, repeated use of rapid point-of-care testing may be superior for overall infection control compared with less frequent, highly sensitive tests with prolonged turnaround times.” Negative tests results should be considered in the context of clinical observations, patient history and infection rates in the location or surrounding community and, if indicated, should be followed with a PCR test. **“It is not necessary to perform confirmatory high-sensitivity tests on individuals with negative antigen test or other point-of-care test results if they are obtained during routine screening or surveillance.”**

3-day stay waiver. LeadingAge has heard from several different states that nursing homes are being told by hospitals that the 3-day stay waiver is no longer in effect or will soon be terminated. We have confirmed with CMS twice in the past week that the waiver is still in effect. When asked why a hospital might be saying it’s terminated, we were told “We can’t comment on a hospital’s individual policies, only on our federal policies.” We’ve reached out to the American Hospital Association to see how we can address this. We’ve received many questions over the past several months about the qualifying hospital stay (3-day stay) and the benefit period waivers. Both waivers are still in effect, both refer to skilled nursing facility services under your Medicare A benefits, but one requires direct impact from COVID-19 and for the other, the impact is assumed and applicable for all. We’ve created [this explainer](#) to hopefully help demystify these 2 waivers and how to take advantage of them.

NHSN updates. NHSN updates will begin collecting data on point-of-care antigen testing in nursing homes. CSV templates will be updated ahead of or along with the NHSN module. Those who are responsible for group reporting should check the [NHSN site](#) for updated templates. NHSN will also be working to transition all users to enhanced security levels within the next 2 months. This is optional and users will be contacted by NHSN in the coming weeks with information on how they can take part. Required reporting will not be interrupted while a user transitions to the upgraded enrollment. NHSN

(CDC) will send out guidance to all reporting providers with instructions on how to start the process and will release a new version of the FAQ. They have also pledged to share this info with the QIOs and with LeadingAge to allow us to help members through this process.

Meeting on PRF Reporting. LeadingAge met with other provider associations including acute care and post acute care organizations where we learned that HHS draft guidance on required reporting for the Provider Relief Fund includes a different interpretation of “lost revenues” than what our understanding has been based on the HHS FAQs. We were told that we misinterpreted the FAQ definition around “lost revenues” and according to an HHS General Counsel, it is their view that it does NOT include reductions in occupancy or shorter lengths of stay or similar items. Their view is that COVID-related costs that exceed revenue or reimbursement are the only things that count. We are hoping this is just a miscommunication between different parts of HHS and can be resolved before the final reporting guidance is issued. The associations have requested and will renew its request to meet with HHS to resolve this issue prior to its issuance of the final guidance. Final guidance is anticipated in September prior to the reporting system launching around October 1.

\$2.5B funds distributed to nursing homes -As part of the CMS announcements this week, they announced that they were distributing \$2.5B to nursing homes We believe this is the \$2.5 billion initial payment out of the \$5 billion allocation announced by HHS and the President in late July. The formula is \$10,000 per nursing home + \$1450 per bed. This aligns with scenarios HHS had discussed with us in recent weeks. Thursday night HHS posted the [terms and conditions](#) for these funds. The use of these funds will be limited to "infection control expenses", which are outlined in more detail in this [article](#)

Provider Relief Fund (PRF) and Paycheck Protection Program (PPP) Funds Reporting on Medicare Cost Reports. HHS released [updated FAQs](#) (press [release here](#)) with more details on how providers should report funds received from PRF and PPP on their Medicare Cost Reports. This reporting applies for Skilled Nursing Facilities, Home Health Agencies and Hospice providers who received funds. PRF and forgiven amounts of PPP funds are to be recorded on the cost report under the “statement of revenues for informational purposes.” Any PPP amounts that aren’t forgiven are Providers whose PPP funds are not reported on the Medicare cost report. Any interest paid on PPP loans may be reported on the cost report as interest expense, similar to other interest expenses.

Providers should not adjust their Medicare cost report expenses based upon PRF payments received but instead need to follow PRF Terms and Conditions related to the use of the funds. Likewise, forgiven PPP amounts should not be offset against expenses “unless those amounts are attributable to specific claims such as payments for the uninsured.”

Elder Justice Reauthorization. The bicameral “Elder Justice Reauthorization Act” (summary [here](#)) has been introduced by House Ways & Means Chairman Richard E. Neal (D-MA), Senate Finance Ranking Member Ron Wyden (D-OR), Senator Bob Casey (D-PA), and Congresswoman Suzanne Bonamici (D-OR). The bill reauthorizes and funds the Elder Justice Act for five years. The bill does not add any new provisions to the current EJA, but does substantially increase funding by \$2.2 Billion for: Elder Abuse forensic centers; the grant program for LTC staffing and technology; Adult Protective Services; the ombudsman program; and LTC investigation systems and training (training for state surveyors who investigate allegations of abuse or neglect and for LTC facilities). Of \$200 Million appropriated to the Social Services Block Grant, \$10 Million is allocated to tribal elder abuse programs. The bill also requires

HHS to evaluate EJA programs and activities to see if they have improved access to and quality of resources for older Americans and their caregivers to prevent, detect and treat elder abuse.

Of particular interest to LeadingAge members (again, this is not new, just additional funding) is funding for grants to programs that offer training and certification to LTC direct care employees, to provide incentives to train for, seek out, and retain these positions. Additional funding is available for grants to LTC facilities to offset costs for certified electronic health records technology designed to improve patient safety and reduce adverse events and complications. The statute authorizes the Secretary to adopt standards and procedures for the exchange and acceptance of clinical data by LTC facilities. A total of \$60 Million is appropriated for FY 2021, with declining amounts for the following years. We hope that this “clean” bill will be considered when Congress returns.

SNF VBP Performance Period Changes for FY2022. The SNF Value-Based Payment program for FY2022 would normally be based upon readmission measure performance between October 1, 2019 and September 30, 2020. However, under the public health emergency, CMS granted an Extraordinary Circumstances Exceptions to reduce reporting burden for the SNF VBP reporting requirements for January 1 through June 30, 2020. Therefore, under the interim final rule, CMS is changing the performance period for the SNF VBP program for FY2022 to include data from April 1, 2019 – 12/31/2019 plus July 1 through September 30, 2020. This provides a full 12 months of data for the calculations. Keep in mind, the SNF VBP program uses claims data so there is nothing new for SNFs to report.

AHRQ/HHS Nursing Home COVID Action Network. Here is [the flyer for the AHRQ Nursing Home COVID Action Network](#), which we described in Friday night’s update. These three sessions are the introduction to the upcoming 16 week learning collaboratives or hubs that every nursing home in the US will be invited – but not required - to join. Those nursing homes/medical directors (not finally decided who exactly) will receive “stipends” from the Provider Relief Fund after completing the 16 week learning collaborative.

Medicaid Information Bulletin from CMS. CMS issued an [Informational Bulletin on Medicaid Reimbursement Strategies to Prevent the Spread of COVID-19 in Nursing Facilities](#). The bottom line is there’s no new information here and no additional funding; the bulletin consolidates the information that is already out there. It could be useful for state Medicaid programs in their decision making and for advocates working with state Medicaid programs. CMS reminds states that they have options to obtain an expedited State Plan Amendment under the Medicaid Disaster Relief SPAs. Once approved the state can increase payments to nursing homes or just certain nursing homes treating COVID diagnosed residents or in outbreak areas. There’s no reference to increased FMAP or that states could or should use CARES Act dollars for this purpose.

Nursing Home reporting review. if you are a CLIA waived organization and you do COVID testing, you must report under HHS lab reporting guidelines in addition to NHSN reporting. There was an article in the NY Post today about the upcoming CMS staff testing rule (coming any day now...). The article also made it sound like there’s a NEW reporting requirement coming that “laboratories -- nursing homes using point of care devices – will be required to publicly report diagnostic test results and costs.” THIS IS NOT NEW. CMS addresses it in [this FAQ](#) (excerpt below). We also touched on it in [this Q&A](#) that we developed.

Fall Advocacy Guide For Members. This fall will be one of the busiest and most consequential for our advocacy efforts. We need to Congress to not only finish the next COVID-19 relief bill but also fund the federal government for 2021 by September 30th. This [article](#) highlights our fall advocacy efforts for our members and we have created a new [Conversations With Congress Fall Advocacy](#) Guide to help plan both in-person and virtual meetings with congressional offices. We are seeing some members of Congress that are open to visiting in a safe and socially distanced outdoor meeting. Please reach out to Joe Franco if your state has interest in working to plan both in-person or virtual congressional meetings.

LeadingAge Student Center -Do you know a student who's curious about the field of aging services? LeadingAge Student Membership offers students interested in careers in aging services access to all the benefits of LeadingAge membership. We recently launched the [LeadingAge Student Center](#) where budding professionals explore careers, events, membership, and more.