

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

The following FAQs are listed by topic in alphabetical order for quick reference. They include website links as information changes quickly. The dates in parenthesis () following each link refer to the last time the link was known to be updated.

Unless otherwise noted, the recommendations relate to a home health, hospice, private duty, infusion, palliative care or DMEPOS provider. **Weekly updates made to topics or websites are noted in red with the corresponding week noted to make it easier to see changes week to week.**

If you have questions or comments, please send them to education@chapinc.org Thank you!!

A

Assisted Living Facility Access:

- Although CMS advises “if the staff is appropriately wearing PPE, and do not meet criteria for restricted access to the facility, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.)”, some ALFs continue to refuse access to home health, hospice or private duty staff. Some recommendations:
 - Contact the administrator and explain the situation, advise what precautions you take with your staff to avoid assigning an ill staff member to their facility, and that you have the PPE needed for the care provided. Also, reinforce that you offer what they cannot provide-clinical care, palliative expertise to manage symptoms, support to the patient and family, and additional help to the resident that the resident has agreed to.
 - If this does not work, determine the ownership of the ALF. This may be a corporation. On the web, identify the organization and look for the clinical executive or the compliance/quality assurance executive, the president or the Chair of the Board. Contact them via phone or e-mail and advise that there are residents that are being denied access to care:
 - For home health and hospice, you have consent forms signed by the patient or representative, and you have doctors’ orders that you can use as evidence of ordered care.
 - Also, remember to advise the patient’s doctor of the inability to deliver care.
 - For private duty, you have authorization to provide services, do not hesitate to enlist the client in the ALF and their designated contacts.
 - In some states the providers have contacted the state licensure office for ALFs (not all states have licensure) as well as other government offices.
 - Remember to document the situation in the record and why services were not provided.
- Does the ALF have a nurse on-site? Some have RN wellness coordinators working in the building. Providers report using FaceTime with the RN working in the facility at the patient’s bedside to evaluate the patient. If the need for your expertise is indicated, it may facilitate your entry. (Shared practice)

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

C

Clinical Study Findings of US COVID 19 Patients:

- **April 13, 2020 Study Findings from first 100,000 COVID 19 US Cases:**
 - The incubation period continues to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.¹⁻³
 - 97.5% of COVID-19 infected persons who develop symptoms, do so within 11.5 days of infection.³
 - The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following^{1,4-9}:

Fever (83–99%)	Cough (59–82%)	Fatigue (44–70%)
Anorexia (40–84%)	Shortness of breath (31–40%)	Sputum production (28–33%)
Myalgias (11–35%)		

- Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have also been reported but are less common (<10%).^{1,4-6}
- **Older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.**^{10,11} Among 1,099 hospitalized patients, fever was present in only 44% at hospital admission but later developed in 89% during hospitalization.¹
- Persons with COVID-19 experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract infection
- **Patients with risk factors for severe illness should be monitored closely given the possible risk of progression to severe in the second week after symptom onset.**^{5,6,10,11}
- **Patients on ACE inhibitors or ARBs may increase the risk of SARS-CoV-2 infection and COVID-19 severity.**⁴⁵The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.⁴⁶

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>
(April 3,2020)

CMS Survey Status:

- **Home Health and Hospice Resurveys:** CMS resurveys for home health and hospice are currently suspended. Visits are limited to complaints indicating immediate jeopardy or serious infection control issues.
 - Accreditation dates will be rolled forward in recognition of this delay.
 - **Deemed organizations missing the renewal date.** CMS assures that if your resurvey date is missed due to the public health emergency, your Medicare/Medicaid billing status is not in jeopardy.
 - **CHAP is sending notifications of accreditation extensions to CHAP accredited organizations whose resurvey date was missed.** If there is an executed renewal contract in place, CHAP will continue to represent the organization’s status as accredited to the public and payers. CHAP will advise you when renewal surveys will begin again.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

- **Initial certification surveys for home care and hospice continue.** The sole barrier to initial certification surveys being conducted may be state licensure.
 - If your hospice or home health is licensed and is ready for the initial survey, CHAP can conduct the review within 30 days.
- **DMEPOS:** CMS has suspended initial and resurveys for 90 days from March 25.
 - **CHAP is sending notifications of accreditation extensions to CHAP accredited DMEPOS whose resurvey date was missed or DMEPOS initial survey delayed.** If there is an executed renewal contract in place, CHAP will continue to represent the organization’s status as accredited to the public and payers. CHAP will advise you when initial and renewal surveys can begin again.

D

DMEPOS

DME Signature Requirement at Delivery Waived: (effective 3/1/20)

- The patient’s signature is waived for those Part B drugs and Durable Medical Equipment (DME) covered by Medicare requiring proof of delivery and/or a beneficiary’s signature.
 - Suppliers should document in the patient record the delivery date and that a signature was not able to be obtained because of COVID-19.

Contractor Flexibility in Requirements for DMEPOS Replacement (effective 3/1/20)

- If durable medical equipment, a prosthetic, orthotic or supply is lost, destroyed, or irreparably damaged or otherwise rendered unusable, contractors can waive replacement requirements such as the face-to-face requirement, new physician’s order, and medical necessity documentation.
 - Suppliers must continue to include a narrative description on the claim explaining why the DMEPOS must be replaced, and maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable due to the Public Health Emergency. www.cms.gov/files/document/covid-dme.pdf
- **DME Retail Closure If a shelter-in-place order is declared:** DMEPOS is considered an essential service in most states. “Essential service” is defined by each state. Whether you stay open is a business decision, and if you can meet social distancing and infection precautions in the retail space. Decide what you will do and document it, including start date.
 - If the retail portion of the company had patients come to the office for CPAP setups, oxygen tank pickup, purchase walkers or canes, you need a process to continue to meet those patients’ needs. Document how you do this, and how you let patients know – the bottom line is meeting patient need.
- **Infection Control for DMEPOS suppliers providing equipment to patients in the home:** Delivery and instruction by your technicians involves the same precautions for staff of home health, hospice and private duty. All the staff recommendations in these FAQs apply to your staff, as well as any

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

additional instructions from manufacturers for cleaning equipment returned from a home with a known or suspected COVID 19 patient.

L

Licensure-Professionals Ability to Work Across State Lines:

- **Are clinicians (RNs, LPNs, PTs, PTAs, OTR, COTA, CNAs) able to cross state lines to perform skilled care?** The recognition of licensure in each state to facilitate care across state lines is a state decision. States may implement recognition of other state licensure during a public health emergency. However, the process can be different in each state.
 - Right now, under the nurse licensure compact (NLC), state boards of nursing may issue registered nurses (RNs) and licensed practical nurses (LPNs) with a multistate license, which allows them to practice both in the state where they legally reside and in all other compact states. More information at: <https://nurseslabs.com/nurse-licensure-compact/>
 - There is also compact state licensure for physical therapists and PTAs, more information at <http://ptcompact.org/>

Licensure: Licensed Practitioners

- **Nurse Practitioners (NP) State Scope of Practice:** CMS' recent approval for licensed practitioners to order and certify patients' eligibility for home health during public health emergency also requires that you understand that the NP providing orders is acting within the scope of their practice in each state. You can use the following website for more information: <https://www.aanp.org/advocacy/state/state-practice-environment>
- **Physician Assistants (PA) State Scope of Practice:** PAs are also licensed practitioners who can order and certify home health. Like NPs, the scope of their practice varies by state. To understand what is required of PAs in your state to provide a valid order for home health, you can use the following website for more information: <http://scopeofpracticepolicy.org/practitioners/physician-assistants/>

State Licensure:

- **New Jersey:** CHAP HCSF licensure questions and DCA advises:
 - Renewal dates will be delayed, no time specified;
 - No statement on the status of those seeking initial licensure;
 - **Division of Consumer Affairs (NJ) suspends the need for a 60 in home evaluation by the nurse practitioner if the patient refuses.** Contact your Director of Accreditation for a copy of the letter. www.njconsumeraffairs.gov (April 6,2020)
- **Criminal background checks at hire:** State background checks often have the most detail, recommend checking your state association or licensing department to assess if any requirements have been waived.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

N

Nursing Home Access for Home Health and Hospice:

- Although CMS advises “if the home health and hospice staff is appropriately wearing PPE, and do not meet criteria for restricted access to the nursing home, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.)”, some nursing homes continue to refuse access to home health or hospice staff. Some recommendations:
 - For patient care purposes, can you use telehealth or face time to work with a facility nurse to assess the patient and their symptoms. (See “T”, telehealth and HIPAA emergency waiver)
 - Contact the administrator and explain the precautions you take with your staff to avoid transmission and advise that you have the PPE needed to deliver care. Also note that you offer what they cannot- clinical care, palliative expertise to manage symptoms, and support to the patient and family.
 - **Hospices:** You may need to remind them of your agreement for delivery of hospice care in the nursing home.
 - Determine the ownership of the nursing home. On the web identify the organization and look for the clinical executive or the compliance/quality assurance executive, the president or the Chair of the Board. Contact them and advise that patients are being denied access to care:
 - Remember you have consent forms signed by the patient or representative, and you have doctors’ orders that you can use as proof of care needed.
 - Remember to advise the patient’s doctor and for hospice patients, the medical director, of the inability to deliver care.
 - Contact the state licensure office for nursing homes, as well as other government offices such as the state Medicare Ombudsman.
 - If the nursing home is also a certified SNF, contact the Medicare regional office.

O

Operational Changes Under COVID-19:

- **Letters for Staff as They Travel:** Nationwide home care and hospice staff are being stopped and asked for reason why they are traveling when there are shelter-in-place orders. Their ID badge is often not enough. We recommend a short letter on your company’s letterhead. The letter can be short, an example follows.

(Name of company) is providing healthcare services. (Name of staff member) is currently assigned to provide these services to one of our patients in their home. They are carrying an ID badge issued by

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

our company. If you have questions, you can reach us at (insert a 24/7 number if your staff could be out at any time). Thank you.

Signed by an Administrator or Director of Nurses (make it someone in management).
Add the CHAP Logo

- **Assessing Readiness for Admitting COVID 19 Patients:** COVID 19 patients are being referred to home health, private duty and hospice organizations across the country. Will your organization accept COVID-19 patients?
If yes, the following questions were shared by call participants as helpful in deciding how many COVID 19 patients they can care for.
 - **Ask staff who will agree to care for a COVID 19 patient.** Organizations report that not all staff will, and some staff have resigned rather than face the prospect.
 - **How much PPE do you have** (e.g. face shields, gloves, gowns, N95 masks) and how much you will need? CDC offers a PPE 'burn rate calculator: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html> (April 7 2020)
 - **Will staff see only COVID 19 patients each day, or mixed with those who are not suspected or confirmed COVID 19?** This decision impacts your PPE inventory. Organizations report two current practices: 1) leave the N95 mask, face shield and gown after use in the patient's home (if not soiled or possibly contaminated, and still 'sound'-not torn, and still fitting appropriately) and place these in a paper bag and the bag inside a box-with cautions for access by pets and children; or 2) staff removes PPE and places the N95 mask in a bag in a box in their trunk, and only uses when they see the next COVID 19 patient. In both instances, hand hygiene is performed per OPIM after removing PPE. (Shared practice not endorsed by the CDC).
 - In view of the **nationwide recommendation, and in some areas a governor's or health department order that the public wear masks**, CHAP recommends that staff wear masks when entering the home of those without confirmed or suspected COVID-19. Staff will likely be within 6 ft of the patient or others in the home.
 - **Organizations also share that when possible they don PPE upon entry the apartment or house** to avoid issues for the patient and family if donned on a porch or in the hallway. PPE is for protection at the bedside with the infected patient, and usually the patient is at least 6ft away when putting on PPE inside the residence (Shared practice).
 - Below under PPE, there is a variety of information to manage your inventory.
- **Referral acceptance, whether home health, hospice, private duty, infusion or DMEPOS referral acceptance should include requesting COVID 19 status:** CHAP recommends adding the question about each patient's COVID 19 status to your referral acceptance process – it is critical to the health of the patient, their family and your staff.
 - Example:
 - Does this patient/client have confirmed COVID-19, or waiting for test results?
 - If the patient has confirmed or suspected COVID 19, remember to get orders for any specific symptom monitoring or intervention for the COVID 19 diagnosis, as well as care for other chronic illnesses.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

- Obtain information for how long transmission-based precautions must be maintained or how you will know that the patient/client is no longer considered infectious. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.**

April 13,2020: The decision to discontinue Transmission-Based Precautions is made using a test-based strategy or non-test-based process (i.e., time-since-illness-onset and time-since-recovery strategy).

- **Test-based:** Note a combination of: -
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal (NP) swab specimens collected ≥24 hours apart (total of two negative specimens) [1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>
(March 23,2020)
- **Non-test-based strategy recognizing the limitations for testing, a combination of:**
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and**
 - improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
 - At least 7 days have passed *since symptoms first appeared*
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>
(April 10 2020)

P

PPE:

- **Accessing PPE**, the National Declaration of an Emergency distributes PPE via two (2) sources:
 - **The county and state health departments** – access to the national supply stockpile is distributed from health departments by on governor’s requests:
 - Contact your state or local health department to request supplies.
 - Also contact your state associations for information about accessing supplies – state associations have been able to identify the process which could be formal request (forms to be completed) or requests e-mailed to the health department or local, regional or national suppliers with inventory.
 - **As PPE continues to be scarce in some areas, several state associations are recommending:**
 - Approaching suppliers with larger orders by partnering with another organization(s);
 - For N95 or other equivalent respirators, be ready with the model number of which masks have been fit tested for your staff. If no model number, provide manufacturer and year from a mask you have.
 - **ASPR Health Care Coalitions:** The following includes a list of organizations that have come together to ensure that providers have what is needed in an emergency. Use the Interactive

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

map in the web location below. Note, those who respond may not have immediately thought of home and community-based care, persist!

- <https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx>
(March 24, 2020)

- **Maximizing PPE:** – the CDC website below offers 5 categories of PPE-specific recommendations to maximize the use of PPE. Note: information is often written with the inpatient setting in mind. Not all categories will apply to care in the home, but many do. Anticipate how to make these protections work in the home care setting.
 - Eye protection
 - Gowns
 - Face Masks
 - N95 respirators – includes fit testing, training on use of respirators, alternative respirators
 - How to calculate your PPE “burn rate” <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html> (April 7 2020)<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html> (April 3, 2020)

April 13,2020: N95 Masks - Particulate filtering facepiece respirators

- There are two types of respirators, standard N95 and surgical N95. When trying to access, you need only N95 or equivalent.
- Respirators are for healthcare staff who need protection from both:1) airborne droplets and 2) fluid as the close fit is to avoid permeation of both.
- A variety of respirators have been approved in addition to the N95: The FDA and the CDC have expanded the types of N95 -like respirators that can be used to include: N99, N100, P95, P99, P100, R95, R99, and R100 and most recently the KN95 respirator mask from China.

April 13, 2020: Conserving Inventory of Respirators: Two (2) Ways to Approach

- **Respirator Extended use:** wearing the same respirator mask for repeated close contact encounters with patients, the maximum recommended extended use period is 8 hrs.
 - Respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.
- **Respirator Re-Use:** using the same respirator by one staff member for multiple encounters with different patients but removing it (i.e. doffing) after each encounter.
 - Data suggest limiting the number of reuses to no more than 5 uses per device to ensure an adequate safety margin.¹
 - One CDC example is to issue 5 respirators to each staff member. Each respirator is used on a day and stored in a breathable paper bag until the next week.
 - This can result in each staff member requiring a minimum of five respirators if they put on, take off, care for them, and store them properly each day. The respirators may need to be stored in the staff’s trunk vs. the home.
 - The amount of time in between uses should exceed the 72-hour expected survival time for COVID-19 virus.³ Healthcare staff should still treat the respirator as though it is still contaminated and follow the precautions.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

- **Note that the re-use of N95 respirators requires 2 pair of gloves**, a clean pair of gloves when donning or adjusting a previously worn N95 respirator. Then discarding these gloves and performing hand hygiene after the N95 respirator is donned or adjusted and using a new pair of gloves for care.
- Use of a cleanable face shield or facemask over the respirator can extend respirator use as it reduces/prevents contamination of the N95 respirator.
- Mask the patients with a surgical mask.
- **Staff reuse of N95 Masks with presumptive or confirmed COVID-19 patients:** Two sources of information on reuse:
 - CDC: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> (April 3 2020)
 - NIOSH the National institutes of Occupational Safety <https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html> (March 27,2020)
 - Inpatient staff recommendations are based on wearing the same staff wearing N-95 masks patient-to-patient for several hours. Using inpatient criteria and applying it to the home, re-use is typically limited by
 - hygienic concerns (the respirator is contaminated with blood, respiratory or nasal secretions, or other patient bodily fluids, or
 - the respirator is damaged or crushed and no longer meets fit test requirements.

April 13, 2020: Discard N95 respirators contaminated with patient blood, respiratory or nasal secretions, or other bodily fluids.

- Discard any respirator that is obviously damaged or becomes hard to breathe through.
- Respiratory pathogens on the respirator surface can potentially be transferred by touch to the wearer's hands and risk causing infection through subsequent touching of the mucous membranes of the face - Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene.

April 13, 2020: Surgical Masks: Fluid-resistant, disposable, and loose-fitting protection devices that create a physical barrier between the mouth and nose of the wearer.

- Surgical masks do not seal tightly to the wearer's face, and therefore do not provide a reliable level of protection from inhaling infectious aerosols.
- Healthcare staff can continue to wear the same surgical mask until obviously soiled or torn-no longer providing protection.

April 13,2020: Gowns: should be worn for aerosol-generating procedures such as suctioning, nebulizer treatments, and other care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers.

Examples of high-contact patient care activities requiring gown use include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, or wound care.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

- Re-usable gowns are available instead of disposable single use gowns – but also require the laundering process.
- Using ANSI/AAMI PB70 standard disposal gowns: Level 1 or 2 gowns (non-surgical isolation gowns) are recommended when there is low risk of contamination. Level 3 or higher for high risk of contamination.

https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html April 9 2020

S

Staff Symptoms: COVID 19 Processes to Address the Following:

- How you monitor staff health status for the presence of the COVID 19 symptoms-fever, coughing, shortness of breath.
 - CHAP conference call participants shared ways that they screen: having staff contact supervisors daily with a health status report; and, leaving a voice message, or an e-mail about their health status (shared practice).
- Staff notification if they are feeling ill:
 - The CDC recommends staff feeling ill go home and contact a doctor for care and/or testing.
- How patients, families and other staff are notified of staff health status if ill. Designate who will advise patients, families, or other staff that a staff member is ill, and what action they should take awaiting information if the staff member will be tested for COVID 19 and when results are received.
- Advise patients and caregivers how you monitor staff health status and ask their cooperation in telling you if any member of the household or visitor is being tested and the results.

T

Telehealth:

- Use of telehealth in private duty Nurse evaluations:
For CHAP accredited private duty organizations, the 60-day in person nurse evaluation may be conducted by telehealth -Skype, face time, if the patient refuses the nurse's entry. CHAP would look to see documentation of the patient's or client's refusal, the results of evaluation and how it was done (e.g. facetime, etc.) See HIPAA waiver below.
NOTE: This method of evaluation may not meet the requirements of state licensure. You must contact state licensure organizations for approval. CHAP has such an inquiry into NJ DCA for HCSF licensure with no response to date.

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

- See the separate documents which provide detail about the use of telehealth in hospice and home health as part of CMS Blanket waivers located at <https://education.chapling.org/>
- **Paid telehealth visits by licensed practitioners.** As of March 6, 2020, Medicare pays for office, hospital visits or visits to a patient’s home furnished via telehealth. These visits can be conducted by doctors, nurse practitioners, clinical psychologists, licensed clinical social workers and other licensed practitioners.
<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> (March 17, 2020)

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for these practitioners to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Think outside the box for other disciplines who provide care:

- Hospice and home health social work visits can be made by telehealth, or even telephone.
- Hospice chaplain visits can be done by telephone or telehealth.
- **HIPAA and Telehealth:** Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.
<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> (March 23, 2020)

W

Waivers:

Three (3) types of 1135 waivers are issued during the Public Health Emergency (PHE). All waivers are effective March 1, 2020. The provisions of each waiver end effective when the President officially ends the Public Health Emergency. NOTE: HHS Secretary Azar can extend that date by 60 days to offer health care providers additional time in ‘ramping up’.

- **Blanket Waivers:** Publicly announced by CMS and applicable to all providers by Medicare benefit type. Examples include the home health and hospice waivers.
- **State Medicaid waivers:** States may request waivers of Medicaid regulations by contacting CMS. Over 48 states have requested waivers. To the following website, find your state, click on what is a letter to the state, scroll past the letter and you will find the details of the waiver.
- **Individual provider or company waivers:** One provider or an association or a company with multiple locations can request a specific waiver of regulation related to the delivery of care. These waivers are not made public unless the requesting organization does so. Example, some state hospital associations have provided copies of their approved waiver that included provisions for home care

FAQs: COVID 19 Conference Calls – Updated Week of April 13, 2020

or hospice. You may find guidelines for an individual waiver at : website

(<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities>)

Send your waiver request to the specific Regional Office with oversight for your state:

ROATLHSQ@cms.hhs.gov (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

RODALDSC@cms.hhs.gov (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

ROPHIDSC@cms.hhs.gov (Northeast Consortium): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

ROCHISC@cms.hhs.gov (Midwest Consortium): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska.

ROSFOSO@cms.hhs.gov (Western Consortium): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, and the Pacific Territories.

Please continue to join CHAP on our Weekly COVID 19 Conference Calls:

- Tuesday 10:30 – 11:30AM ESDT Call in: 646-307-1479/toll-free 877-304-9269 with • Participant code is 246854#
- Wednesday 11AM – Noon ESDT Call in: 646-307-1479, or toll-free 877-304-9269 • Participant code is 246854#
- Thursdays 3 -4:00 PM ESDT Call in: 646-307-1479, or toll-free 877-304-9269 • Participant code is 246854#

Thank you for your dedication and be well!