

Frequently Asked Questions

Updated: October 23, 2020

On March 13, 2020, Governor Greg Abbott declared a state of disaster for all counties in Texas due to the COVID-19 pandemic and directed state agencies to restrict visitation at nursing facilities (NFs) to protect those most vulnerable to COVID-19. In addition, the Centers for Medicare and Medicaid Services (CMS) [directed](#) all NFs to restrict visitation and allow access only to staff or other individuals providing critical services.

The Texas Health and Human Services Commission (HHSC) is committed to sharing pertinent COVID-19 information with all NFs via a regularly updated Frequently Asked Questions (FAQs) document.

With each update, information in this FAQ document will be arranged by topic, and if guidance changes from previous FAQs, it will be noted in red font. Questions regarding these FAQs can be directed to Long-term Care Regulatory Policy, Rules & Training at PolicyRulesTraining@hhsc.state.tx.us.

The frequently asked questions document includes a table of contents to make it easier to use. Just click on a topic or question to automatically be redirected to a specific place on the page.

These frequently asked questions are published to offer providers resources to consult when they are making decisions. They are guidance, recommendations, and best practices that LTC Regulation has collected for the convenience of the providers, to assist in decision making related to the health and safety of residents during this unprecedented time.

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CMS Requirements

When does the CMS-mandated testing requirement go into effect?

Response: The rules took effect on September 2, 2020, and surveyors began surveying for compliance with the requirement on that date.

What does a provider do if an employee refuses testing? Does the employee get sent home for 14 days?

Response: A NF must develop policies and procedures for staff refusal of routine testing, outbreak testing, and testing because the person has signs or symptoms of COVID-19.

Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed.

A NF should consult its human resources and legal departments for guidance on staff refusal of routine testing. A NF's policies about an employee's individual position regarding testing should be based on the employee's reasons for declination and the facility's policy on hiring and refusal.

There is no public health basis for quarantine of an individual who has not been exposed. Sending someone home for 14 days provides no greater assurance of remaining COVID-19 free than someone who was tested and then works for 14 days. However, a NF must take precautions to ensure the health and safety of the residents and other employees so they are not harmed by the employee's refusal of routine testing.

What if staff is on vacation when testing is done?

Response: If an employee is on vacation when staff testing is done, the employee should be tested immediately upon return from vacation and then tested with the rest of the staff afterward. A NF should document the reasons an employee is not tested.

Is testing required for all staff or just direct care staff?

Response: Per the CMS rules and guidance, testing is required for all staff,

including individuals providing services under arrangement and volunteers.

Does a nursing facility need to re-test residents and staff if the person had a previous positive result and is no longer considered contagious?

Response: No. Per CMS [QSO 20-38](#), staff and residents who have recovered from COVID-19 and are asymptomatic do not need to be retested for COVID-19 within three months after symptom onset. However, if staff or a resident becomes symptomatic within the three-month timeframe, the nursing facility must test the staff or resident. Also, if more than three months have passed since symptom onset, nursing facilities must test staff and residents based on the indicators described in QSO 20-38.

What if we can't find a laboratory that can quickly process large numbers of tests with rapid reporting results?

Response: If a facility cannot find a laboratory that meets testing requirements due to community testing supply shortages, or limited access, the facility should have documentation of its efforts to obtain quick turnaround test results with laboratories, as well as its contacts with local and state health departments.

What is a laboratory?

Response: Under the Clinical Laboratory Improvement Amendments (CLIA), a laboratory is defined as a facility that performs applicable testing on materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or assessment of the health of, human beings.

How often does a nursing facility need to check the county positivity rates?

Response: Per [QSO 20-38](#), providers should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing accordingly.

If the required frequency for staff testing changes based on an increase or decrease in the county positivity rates, how soon do we need to change to the new testing frequency?

Response: Per [QSO 20-38](#), the provider should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week.

- If the county positivity rate increases, the facility should begin testing staff at the frequency shown in the table below as soon as the criteria for the

higher level of testing are met.

- If the county positivity rate decreases, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

Community COVID-19 Activity	County Positivity Rate in the past week	Minimum Testing Frequency
Low	<5% (green)	Once a month
Medium	5% -10% (yellow)	Once a week*
High	>10% (red)	Twice a week*

Are we required to test consultants or doctors who visit the facility monthly as often as regular staff?

Response: Per [QSO 20-38](#), a facility should prioritize testing those who fall under the definition of “facility staff” who are more frequently in the facility (e.g. on a weekly basis). For less frequent visitors, the facility can determine testing based on the frequency of the visits and their contact with residents. Either way, these visitors need to be screened before entering the facility and barred from entering the facility if they meet any of the requirements laid out in the [COVID-19 mitigation rules](#).

Has there been any guidance to whose responsibility it is to test the contract staff, consultant staff, volunteers, etc.?

Response: The facility and the contractor can enter into agreements/contracts that delineate testing responsibility; however, the facility is responsible for ensuring that the contractor is being tested in accordance with CMS rules (whether that be through the facility or elsewhere). If the contractor is being tested elsewhere (through another facility/agency), then the facility will need to acquire the documentation of the contractor’s test results to ensure the timing/frequency of testing is in line with the facility’s requirements.

For facilities that are required to test twice per week, what do we do about PRN staff or weekend-only staff who aren’t able to come in during the week? Are they still required to be tested twice?

Response: Yes, staff working in the facility regularly, including PRN staff or weekend-only staff, should be tested at the same frequency as other staff. CMS has not issued guidance on how many days should pass between twice weekly testing. Per CMS guidance, [QSO-20-38](#), staff who are in the facility every week

would be considered “regularly in the facility” and should be prioritized for testing. [QSO-20-38](#) also states that facilities should refer to CDC guidance when conducting testing. Current [CDC guidance](#) is to not perform more than one test within a 24-hour period.

[QSO-20-38](#) does not state that staff must be tested on days they are working. Ultimately, the provider will have to determine how it can accomplish the testing requirements, whether that be on days the staff is working (taking the 24-hour period from CDC guidance into consideration) or under alternative arrangements, such as testing staff on days they are not working or other arrangements that meet the requirement for twice-weekly testing.

Testing Resources

Can providers use Omnicare to fulfill the CMS testing requirements?

Response: While Omnicare is not able to fulfill the testing requirements on an ongoing basis, providers can contact Omnicare as a supplemental resource as needed. Facilities requesting COVID-19 testing through Omnicare should contact the LTCR Regional Director for the region in which the facility is located.

Where do providers find community prevalence/positivity data to determine how often staff must be tested?

Response: The information can be found on the [CMS COVID-19 nursing home data](#) website.

Point-of-Care Antigen Testing

Whom can providers contact for help in obtaining POC testing machines and test kits, or in identifying labs that can test per CMS requirements?

Response: Providers should contact labs that provide other lab services. The local health authority with jurisdiction over the facility and the Texas Department of State Health Services (DSHS) also might be able to help providers that are unable to find lab services that meet CMS requirements.

Can a nursing facility use the rapid point-of-care (POC) diagnostic testing devices for weekly staff and resident testing?

Response: Yes, a nursing facility can use the rapid POC diagnostic testing devices for staff or resident testing. Please note: per [QSO 20-38](#), CMS does not

recommend that nursing facilities test residents on a weekly basis unless there is an outbreak in the facility. CMS defines an outbreak as: “a new COVID-19 infection in any health care personnel or any [nursing facility-onset](#) COVID-19 infection in a resident.”

If the results from the antigen test are negative, is a PCR test required?

Response: If an antigen test result is negative and there is no known exposure and no symptoms present, a nursing facility can proceed under the assumption that the negative test is accurate. If an antigen test is negative and there is known exposure and/or symptoms, the test result must be verified with a PCR test.

If a nursing facility hasn't received its POC testing device yet, does it still have to test residents and staff for COVID-19?

Response: Yes, a nursing facility is still required to test residents and staff for COVID-19. Per [QSO 20-38](#), nursing facilities without the ability to conduct COVID-19 POC testing should have arrangements with a laboratory to conduct tests to meet the testing requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected to rapidly inform infection prevention initiatives to prevent and limit transmission.

Does a nursing facility need a CLIA Certificate of Waiver to administer a COVID-19 test using a rapid POC diagnostic testing device?

Response: Yes, to perform the POC test a nursing facility must have a CLIA Certificate of Waiver or be certified as a laboratory. A nursing facility can apply for a CLIA Certificate of Waiver by completing an application ([Form CMS-116](#)) available on the [CMS CLIA](#) website or the [HHSC Health Care Facilities Regulation - Laboratories](#) website. The applicant submits the application to HHSC HCF Regulation - Laboratories.

Please note, for the CMS-116 application, CMS recommends that nursing facilities fill out section 1 this way: “please select ‘Other Changes (Specify)’ and fill in ‘COVID 19 NH’ to alert the state agency that your application is part of the HHS effort.”

What is a waived test?

Response: As defined by CLIA, waived tests are categorized as “simple laboratory

examinations and procedures that have an insignificant risk of an erroneous result.” The Food and Drug Administration (FDA) determines which tests meet these criteria when it reviews manufacturers’ applications for a test system waiver.

Is a nursing facility required to report COVID-19 test results? How are the test results reported?

Response: Yes. A nursing facility that performs or analyzes any test that is intended to detect COVID-19 or to diagnose a possible case of COVID-19 (e.g., molecular, antigen, antibody) must have a CLIA Certificate of Waiver or be certified as a laboratory and must report all test results, including positive, negative, or indeterminate results. If the test is conducted by a laboratory and not the nursing facility, the laboratory is responsible for reporting the test results.

The test results are [reported to DSHS](#) and the local health department. A nursing facility must register and onboard with DSHS following the instructions for complying with governor’s order to report COVID-19 lab test results in Texas. A nursing facility must also contact the local health department and follow its requirements for reporting COVID-19 test data.

Can a nursing facility perform tests other than waived tests if it has a Certificate of Waiver?

Response: No, only those tests that are CLIA-waived can be performed by a laboratory (a NF) with a Certificate of Waiver.

The FDA has issued an approved emergency use authorization for the Abbott BinaxNOW COVID-19 rapid antigen test. Is this as an acceptable diagnostic screening product?

Response: Yes, the Abbot BinaxNOW rapid antigen test is an acceptable diagnostic screening product. The Abbott BinaxNOW test is an FDA emergency use authorization approved antigen test, just like the BD Veritor and Quidel COVID-19 test devices that are being provided to nursing facilities. The medical director for the nursing facility should determine which rapid POC diagnostic testing device should be used.

Is a doctor’s order needed before the nursing facility can perform the POC test?

Response: Per [QSO 20-38](#) and in accordance with 42 CFR [§483.50\(a\)\(2\)\(i\)](#), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law, including

scope of practice laws, to provide or obtain laboratory services for a resident, which includes COVID-19 testing (see F773). This can be accomplished through the use of physician approved policies (e.g., standing orders), or other means as specified by scope of practice laws and facility policy.

Rapid POC testing devices are prescription use tests under the Emergency Use Authorization and must be ordered by a health care professional licensed under the applicable state law or a pharmacist under HHS guidance. Accordingly, the facility must have an order from a health care professional or pharmacist, to perform a rapid POC COVID-19 test on an individual.

Where can I find more information about POC diagnostic testing devices?

Response: The manufacturers have made information available on the internet. Additionally, CMS has published [Frequently Asked Questions](#) related to COVID-19 testing at skilled nursing facilities/nursing facilities. The FAQs include information such as:

- identification of providers receiving POC diagnostic testing devices
- the timeline and prioritization for receiving the device
- training resources
- safety considerations
- storage and shelf-life
- CLIA

How do providers bill/get reimbursed for tests?

Federal Funding Distribution to Nursing Facilities

- The U.S. Department of Health and Human Services (HHS) has earmarked \$5 billion dollars for nursing facilities.
 - According to this [article](#) and some public statements by Administrator Verma, HHS will distribute \$2.5 billion to providers directly to be spent on PPE, testing, and staffing. The funds will be divided among the 15,400 nursing facilities across the country. The amount each facility receives will be based on its bed count and whether the facility has received a point of care testing machine.
 - And additional \$2 billion will go into value-based payments tied to COVID metrics that CMS will set.
 - Administrator Verma mentioned on an August 25 call that there would be an enhanced Medicaid rate for testing and additional flexibility for

Medicare residents to have their testing paid for beyond just medically necessary tests. HHSC is seeking clarification on these points.

- The Trump administration announced a \$750 million agreement to purchase 150 million rapid COVID-19 testing kits from Abbott Laboratories in a bid to significantly expand the nation's testing capabilities. Abbott said it plans to ship tens of millions of tests next month and increase production to 50 million tests in October; that monthly figure would roughly double the number of tests performed in the United States last month. ([The Wall Street Journal](#))

Additional funds

- Other distributions of federal funds for nursing homes:
 - HHSC has allocated \$3.6 million of CMP funds for nursing facilities to purchase technology to help residents communicate with their loved ones during the pandemic. Providers are eligible to receive up to \$3,000 per facility for devices such as iPads, tablets, or webcams and accessories such as headphones.
 - On October 1, Governor Abbott announced \$3.5 million in federal funding for nursing facilities to purchase plexiglass barriers and tents to allow for safe visitation during the COVID-19 pandemic. Starting October 5, nursing facilities in Texas are encouraged to submit applications to HHSC to receive this funding to allow residents to have in-person visitation with their loved ones under HHSC's new [expanded visitation rules](#), which apply statewide.

QIPP Funding

- The Quality Incentive Payment Program (QIPP) also announced a funding pool of \$1 billion for FY21. The metrics for FY21 will remain the same as FY20, which include:
 - Component 1 – Quality Assurance and Performance Improvement (QAPI) meetings. This component is open to non-state government-owned providers and funds are distributed on a met/not met basis of one metric: that a facility holds a QAPI meeting each month in accordance with federal requirements.
 - Component 2 – Workforce Development. Open to all providers, this component has three equally weighted metrics for nursing facilities to maintain additional hours of registered nurse staffing coverage per day

beyond the CMS mandate, as well as to have a staffing recruitment and retention program that includes a self-directed plan and monitoring outcomes.

- Component 3 – Minimum Data Set CMS Five-Star Quality Measures. Open to all providers, this component has three equally weighted metrics that are measured against fixed as well as facility-specific targets.
- Component 4 – Infection Control Program. Open to non-state government-owned providers, there are three equally weighted metrics related to an infection control program that include antibiotic stewardship and the incorporation of policies and training as well as monitoring, documenting, and providing staff with feedback.

Medically Necessary Testing Payments

- An additional item to consider is whether private insurance will pay for surveillance testing if it is not considered medically necessary. It is unclear if the insurance plans will simply require a co-pay for this testing or if it is not covered at all. For reference, a summary of medically necessary testing payments is as follows:
 - The CARES Act mandates that private insurance cover testing costs with no cost-sharing or prior authorization for tests that are medically necessary. Staff or residents with private insurance will not incur co-pay costs for these tests.
 - The CARES Act waives cost-sharing (including deductibles, copayments, and coinsurance) for Medicare Part B enrollees for COVID-19 testing-related services. Per [CMS guidance](#), Medicare covers lab administration of testing for residents, including persons who are dually eligible.
 - Medicaid covers COVID-19 testing. Nursing facilities can contract with a provider or lab to conduct testing.
 - For uninsured staff or residents, The Families First Coronavirus Act of 2020 included \$1 billion under the Public Health and Social Services Emergency Fund for testing services for the uninsured. Providers can enroll through the [COVID-19 Uninsured Program Portal](#) and request claims reimbursement while funding is available.