PUBLIC ASSISTANCE COVID-19 SYMPTOMATIC AND ASYMPTOMATIC TESTING TRACKING #35 – 7/17/20

Please ensure as you are tracking COVID-19 testing expenses that symptomatic and asymptomatic testing is tracked separately. Asymptomatic testing is not an eligible expense for FEMA Public Assistance and applicants will need to use other funding available for reimbursement of costs associated with asymptomatic testing.

For additional information, please refer to the documents attached.

Additional DEM Bulletins, FEMA Fact Sheets, and additional recovery resources can be found on the DEM Website at https://dem.nv.gov/COVID-19/home/

FOR QUESTIONS, PLEASE CONTACT:	
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Coronavirus (COVID-19) Pandemic: Medical Care Costs Eligible for Public Assistance

FEMA Policy FP 104-010-04

BACKGROUND

Under the President's March 13, 2020 COVID-19 emergency declaration[1] and subsequent major disaster declarations for COVID-19, state, local, tribal, and territorial (SLTT) government entities and certain private non-profit (PNP) organizations are eligible to apply for assistance under the FEMA Public Assistance (PA) Program. This policy is applicable to eligible PA Applicants only and is exclusive to emergency and major disaster declarations for the COVID-19 pandemic.

PURPOSE

This policy defines the framework, policy details, and requirements for determining the eligibility of medical care costs under the PA Program to ensure consistent and appropriate implementation across all COVID-19 emergency and major disaster declarations. Except where specifically stated otherwise in this policy, assistance is subject to PA Program requirements as defined in Version 3.1 of the Public Assistance Program and Policy Guide (PAPPG).[2]

PRINCIPLES

A. FEMA will provide assistance for medical care provided under COVID-19 declarations to improve the abilities of communities to effectively respond to the COVID-19 Public Health Emergency.

B. FEMA will implement this policy and any assistance provided in a consistent manner through informed decision making and review of an Applicant's supporting documentation.

C. FEMA will engage with interagency partners, including the U.S. Department of Health and Human Services' (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC), the Health Resources

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[1] www.fema.gov/news-release/2020/03/13/covid-19-emergency-declaration.
[2] The current version of the Public Assistance Program and Policy Guide (PAPPG), Version 3.1, is available on the FEMA website at www.fema.gov/media-library/assets/documents/111781.

and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS) to ensure this assistance is provided in a coordinated manner without duplicating assistance.

REQUIREMENTS

A. APPLICABILITY

Outcome: To establish the parameters of this policy and ensure it is implemented in a manner consistent with program authorities and appropriate to the needs of the COVID-19 Public Health Emergency.

1. This policy applies to:

    a. All Presidential emergency and major disaster declarations under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), as amended, issued for the COVID-19 Public Health Emergency.

    b. Eligible PA Applicants under the COVID-19 emergency declaration or any subsequent COVID-19 major disaster declaration, including:
        i.   SLTT government entities; and
        ii. PNP organizations that own and/or operate medical facilities, as defined in Title 44 of the Code of Federal Regulations (44 C.F.R.) §206.221(e)(5).

    c. This policy does not apply to any other emergency or major disaster declaration.

B. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 MEDICAL CARE

Outcome: To define the overarching framework for all eligible medical care work related to COVID-19 declarations.

1. All work must be necessary as a direct result of the emergency or major disaster in accordance with 44 C.F.R. §206.223(a)(1).

2. Medical care and associated costs refer to assistance to support the provision of medical care, including eligible facility, equipment, supplies, staffing, and wraparound services (as defined in the **Definitions** section at the end of this document), as well as assistance for clinical care of patients not covered by another funding source as described throughout this policy.

C. ELIGIBLE MEDICAL CARE WORK AND COSTS BY FACILITY TYPE

Outcome: To establish parameters for eligible medical care work and costs for COVID-19 declarations based on the type of facility providing medical care.

1. Primary Medical Care Facility.

    For medical care provided in a primary medical care facility (as defined in the **Definitions** section at the end of this document), work must be directly related to the treatment of

COVID-19 patients. Work may include both emergency and inpatient treatment of COVID-19 patients; this includes both confirmed and suspected cases of COVID-19. Medical care related to treatment of a non-COVID-19 illness or injury in a primary medical care facility is not eligible. The following medical care activities and associated costs are eligible in primary medical care facilities:

a. Emergency and inpatient clinical care for COVID-19 patients, including, but not limited to:
    i. Emergency medical transport related to COVID-19;
    ii. Triage and medically necessary tests and diagnosis related to COVID-19 patients;
    iii. Necessary medical treatment of COVID-19 patients; and
    iv. Prescription costs related to COVID-19 treatment.

b. Purchase, lease, and delivery of specialized medical equipment necessary to respond to COVID-19 (equipment purchases are subject to disposition requirements[3]);

c. Purchase and delivery of PPE, durable medical equipment, and consumable medical supplies necessary to respond to COVID-19 (supply purchases are subject to disposition requirements[4]);
    i. This includes the costs of eligible SLTT government Applicants providing PPE to any public or private medical care facility that treats COVID-19 patients.

d. Medical waste disposal related to COVID-19; and

e. Certain labor costs associated with medical staff providing treatment to COVID-19 patients may be eligible as outlined below. Any labor costs for medical staff that are included in patient billing and/or otherwise covered by another funding source (as described in **Section D.4 Duplication of Benefits** of this policy) are not eligible for PA. Otherwise, the following labor costs may be eligible:
    i. Overtime for budgeted medical staff providing treatment to COVID-19 patients;
    ii. Straight time and overtime for temporary medical staff providing treatment to COVID-19 patients; and
    iii. Straight time, overtime, and other necessary costs for contract medical staff providing treatment to COVID-19 patients. Work and associated costs must be consistent with the scope of the contract and may include costs for travel, lodging, and per diem for contract medical staff from outside the local commuting area.

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[3] As described in Chapter 2:V.E. Disposition of Purchased Equipment and Supplies of the PAPPG (V3.1).
[4] Id.

f. For primary medical care facilities, increased operating costs for administrative activities (such as medical billing) are not eligible.[5]

2. Temporary and Expanded Medical Facilities.[6]

    FEMA may approve work and costs associated with temporary medical facilities or expanded medical facilities when necessary in response to the COVID-19 Public Health Emergency. These facilities may be used to treat COVID-19 patients, non-COVID-19 patients, or both, as necessary. Medical care activities and associated costs related to treating both COVID-19 and non-COVID-19 patients in a temporary or expanded medical facility may be eligible.

    a. Costs must be reasonable and necessary based on the actual or projected need. The projected needs (i.e., capacity and capability) for a temporary or expanded medical facility must be supported by predictive modeling or other substantiating information used to determine the projected need.

    b. Eligible costs for temporary and expanded medical facilities include:
        i.   All eligible items and stipulations included in **Section C.1 Primary Medical Care Facility**, but applicable to both COVID-19 and non-COVID-19 patients;
        ii. Lease, purchase, or construction costs, as reasonable and necessary, of a temporary facility as well as reasonable alterations to a facility necessary to provide medical care services;[7]
        iii. Mobilization and demobilization costs associated with setting up and closing the temporary or expanded medical facility;
        iv. Operating costs including equipment, supplies, staffing, wraparound services (as defined in the **Definitions** section at the end of this document), and clinical care not covered by another funding source; and
        v.   Maintenance of a temporary or expanded medical facility in an operationally ready but unused status available for surge capacity for COVID-19 readiness and response when necessary to eliminate or lessen an immediate threat to public health and safety, based on public health guidance, location of areas expected to be impacted, and local/state hospital bed/ICU capacity.

    c. For contract costs related to establishing and/or operating a temporary or expanded medical facility, contracts must include a termination for convenience clause that will be implemented if the site is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity.
        i.   Ongoing and projected needs regarding continuing operations at a temporary or expanded medical facility should be based on regular assessments and the Applicant must document the review process to support its decision making.

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[5] See Chapter 2:VI.B.2. Expenses Related to Operating a Facility or Providing a Service of the PAPPG (V3.1).
[6] Temporary medical facilities may include Alternate Care Sites or Community Based Testing Sites if eligible work and costs related to these facilities are incurred by eligible PA Applicants.
[7] As described in Chapter 2:VI.B.17(e) and (g) of the PAPPG (V3.1).

ii. The assessments should include adjustments to projected needs based on guidance from public health officials, caseload trends, and/or other predictive modeling or methodologies; lead times and associated costs for scaling up or down based on projected needs; and any other supporting information.

iii. The assessments and supporting information are necessary to determine eligibility of claimed costs and should align with PA reasonable cost guidance provided in the PAPPG[8] and the *Public Assistance Reasonable Cost Evaluation Job Aid*.[9]

d. Costs related to expanding a primary medical care facility to effectively respond to COVID-19 must be feasible and cost effective. In most cases, permanent renovations are not eligible unless the Applicant can demonstrate that the work can be completed in time to address COVID-19 capacity needs and is the most cost-effective option. Permanent renovations and other improvements to real property with PA funds are subject to real property disposition requirements.[10]

e. For temporary and expanded medical facilities, and the specific type of temporary medical facilities known as Alternate Care Sites, administrative activities and associated costs necessary for the provision of essential medical services are eligible.

D. GENERAL ELIGIBILITY CONSIDERATIONS FOR COVID-19 COSTS

Outcome: To provide additional information about eligible costs and cost-related considerations.

1. Eligible claimed costs must be necessary in order to respond to the COVID-19 Public Health Emergency and reasonable pursuant to Federal regulations and Federal cost principles.[11] A cost is considered reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. All costs are subject to standard PA program eligibility and other Federal requirements. For COVID-19 declarations, FEMA will use Medicare rates[12] as the basis to determine reasonable costs for eligible clinical care not covered by another funding source. Both patient payments and insurance payments are considered another funding source; clinical care for which providers have received or will receive payments from patients or insurance is not eligible.

2. Cost Share for COVID-19 Declarations. PA funding authorized under COVID-19 declarations is subject to the following cost share provisions:

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[8] As described in Chapter 2:V. Cost Eligibility of the PAPPG (V3.1).

[9] The Public Assistance Reasonable Cost Evaluation Job Aid is available on the FEMA website at www.fema.gov/media-library/assets/documents/90743.

[10] As described in Chapter 2:V.F. Disposition of Real Property of the PAPPG (V3.1).

[11] 2 CFR §200.404.

[12] FEMA will use standard Medicare rates that do not include the 20 percent increase in COVID-19 Medicare DRG rates implemented by the CARES Act.

a. Eligible costs incurred by an eligible Applicant claiming reimbursement through PA are subject to the non-federal cost share established for the respective emergency or major disaster declaration. Pursuant to sections 403(b) and 503(a) of the Stafford Act, the federal share for FEMA PA funding is not less than 75 percent of eligible costs.

b. Direct Federal Assistance provided under Stafford Act authorities is also subject to the cost share established for the respective emergency or major disaster declaration, unless otherwise stipulated.

c. Federal assistance provided by other federal departments and agencies, including instances in which provision of the assistance is facilitated by FEMA, is funded at the cost share of the other federal department or agency, some of which may be provided at 100 percent federal funding.

d. In most cases, federal assistance provided by other federal departments and agencies cannot be used to cover the non-federal cost share. The Applicant can only apply other federal award funds toward the PA non-federal cost share if the other federal award has specific statutory authority allowing it to be utilized to meet cost-share requirements, or is otherwise allowable under the other federal source of funding.

e. The Applicant cannot apply PA funds toward the non-federal cost share of other federal agency funding. For example, States may not use PA funding to meet the State share of Medicaid or the Children's Health Insurance Program (CHIP).[13]

3. Procurement Requirements for COVID-19 Declarations.[14]

a. States and territorial governments are required to follow their own procurement procedures as well as the Federal requirements for procurement of recovered materials and inclusion of required contract provisions per 2 C.F.R. §§ 200.317, 200.322, and 200.326 and Appendix II to 2 CFR Part 200.[15]

b. Tribal governments, local governments, and PNPs must comply with the requirements of 2 C.F.R. §§ 200.318-200.326.

c. In accordance with the March 17, 2020, memorandum from David Bibo, Acting Associate Administrator for the Office of Response and Recovery, and Bridget E. Bean, Assistant Administrator, Grant Programs Directorate, for the duration of the Public Health Emergency, as determined by HHS, local governments, tribal

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[13] See 42 C.F.R. § 433.51 and 45 C.F.R. § 75.306.
[14] Additional guidance regarding procurement standards is available at https://www.fema.gov/procurement-disaster-assistance-team.
[15] For additional guidance regarding required contract clauses, see the Procurement Disaster Assistance Team's "FEMA Contract Provisions Template" (2019 ed.), available online at https://www.fema.gov/media-library-data/1569959119092-92358d63e00d17639d5db4de015184c9/PDAT_ContractProvisionsTemplate_9-30-19.pdf.

governments, nonprofits, and other non-state entities may proceed with new and existing non-competitively procured contracts using the exigent/emergency circumstances exception in 2 C.F.R. § 200.320(f)(2). The March 17, 2020 memorandum and other information related to procurement specific to COVID-19 declarations are available on the FEMA website at www.fema.gov/media-library/assets/documents/186350. Additional resources on COVID-19 specific to grants are also available at www.fema.gov/grants under "News and Announcements" and www.fema.gov/coronavirus.

d. SLTT governments may contract with medical providers, including private entities, to carry out any eligible activity described in **Section C. Eligible Medical Care by Facility** of this policy.

e. Contracts must include an actionable termination for convenience clause that will be implemented if any part of the scope of the contract is ultimately not needed, or the needs are less than projected, as determined by the legally responsible entity. Ongoing and projected needs should be based on regular reviews and the Applicant must document the review process to support its decision making. All claimed contract costs must be necessary and reasonable pursuant to applicable Federal regulations and Federal cost principles.

4. Duplication of Benefits.

Pursuant to Section 312 of the Stafford Act, FEMA is prohibited from providing financial assistance where such assistance would duplicate funding available from another program, insurance, or any other source for the same purpose.

a. FEMA cannot duplicate assistance provided by HHS or other federal departments and agencies. This includes, but is not limited to, funding provided by the programs listed below. FEMA is providing this list as a helpful reference, but SLTT government entities and PNPs should consult with the appropriate federal agency and the terms and conditions of each program or source of funding to determine what funding may be considered duplicative.
   i. The Public Health Emergency Preparedness Cooperative Agreement Program;
   ii. The Public Health Crisis Response Cooperative Agreement;
   iii. The Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases;
   iv. The Hospital Preparedness Program Cooperative Agreement;
   v. The Regional Ebola and Other Special Pathogen Treatment Centers Cooperative Agreement;
   vi. The National Emerging Special Pathogens Training and Education Center Cooperative Agreement;
   vii. The Hospital Association COVID-19 Preparedness and Response Activities Cooperative Agreement;
   viii. The Coronavirus Relief Fund and the Provider Relief Fund;

  ix.   The COVID-19 Uninsured Program; and

  x.   The Paycheck Protection Program.

b. FEMA cannot provide PA funding for clinical care costs funded by another source, including private insurance, Medicare, Medicaid/CHIP, other public insurance, a pre-existing private payment agreement, or the COVID-19 Uninsured Program for uninsured patients.[16] The Applicant will certify that it has not received and does not anticipate receiving assistance from these sources or any other source for the same work or costs. FEMA will deobligate any PA funding that has been provided in the event that another source provides funds to the Applicant for the same clinical care costs.

c. At no time will FEMA request or accept any Personally Identifiable Information related to the medical care of individual COVID-19 patients.

d. FEMA will reconcile final funding based on any funding provided by another agency or covered by insurance or any other source for the same purpose. FEMA will coordinate with HHS to share information about funding from each agency to assist in preventing duplication of benefits.

5. Time Limitations for the Completion of Work.

a. Costs for eligible medical care for COVID-19 declarations are limited to those incurred within six months of the date of the declaration in accordance with regulatory timeframes for emergency work at 44 C.F.R. §206.204(c) or until the end of the COVID-19 Public Health Emergency, whichever comes first.

b. For all COVID-19 declarations, FEMA may extend the deadline in accordance with 44 C.F.R. §206.204(d) if the duration of the COVID-19 Public Health Emergency extends beyond six months or for work required after the end of the Public Health Emergency, such as demobilization of temporary medical facilities, or to address localized needs as appropriate.

_____
Keith Turi
Assistant Administrator, Recovery Directorate

    May 9, 2020
_____
Date

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[16] The COVID-19 Uninsured Program reimburses for testing and clinical care costs for the uninsured which is being provided at Medicare rates.

ADDITIONAL INFORMATION

REVIEW CYCLE
This policy will be reviewed periodically during the COVID-19 Public Health Emergency period. The Assistant Administrator for the Recovery Directorate is responsible for authorizing any changes or updates. This policy will sunset with the closure of the national emergency declaration for COVID-19 and any subsequent major disaster declarations for COVID-19.

AUTHORITIES and REFERENCES

Authorities
Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121-5207, as amended

Title 44 of the Code of Federal Regulations, Part 206, Subpart H

Title 2 of the Code of Federal Regulations, Part 200

References
Public Assistance Program and Policy Guide, Version 3.1

DEFINITIONS
To establish consistent terminology for purposes of implementing this policy, the following definitions are provided below. These definitions are specific to this policy and may differ from definitions prescribed for the same or similar terms in other policies.

1. **Medical Care:** Medical Care refers both to assistance provided to support the provision of medical care and assistance for clinical care. Examples of medical care support include eligible facility, equipment, supplies, and staffing costs.

2. **Clinical Care:** Clinical Care refers to medical treatment of individual patients including testing, diagnosis, treatment, hospitalization, prescriptions, and other costs associated with individual patient treatment typically billed to individual patients, their insurance carriers, Medicare, Medicaid, or other pre-existing payment agreements.

3. **Primary Medical Care Facility:** A primary medical care facility is the facility owned and/or operated by an eligible PA Applicant that provides medical care services. This includes any licensed hospital, outpatient facility, rehabilitation facility, or facility for long-term care.

4. **Temporary Medical Facility:** A temporary medical facility is a facility separate from the primary medical care facility that is used to provide medical care services when the primary medical care facility is overwhelmed by the declared event.

5. **Expanded Medical Facility:** An expanded medical facility is part of the primary medical care facility and refers to an expansion of the primary medical care facility to increase its capacity when the primary medical care facility is overwhelmed by the declared event.

6. **Alternate Care Sites:** Alternate Care Site is a type of Temporary Medical Facility and broadly describes any building or structure of opportunity converted for healthcare use. It provides additional healthcare capacity and capability for an affected community separate from a traditional, established healthcare institution, though healthcare institutions may partner with eligible Applicants operating an Alternate Care Site.

7. **Community-Based Testing Sites:** Community-Based Testing Sites are strategically located sites within a community operated by a SLTT government for the purpose of providing COVID-19 testing to members of the community.

8. **Wraparound Services:** Wraparound services in the context of this policy are the same as those defined in the Alternate Care Site Toolkit. The services will differ at each temporary medical facility. Such services include, but are not limited to, the following: linen and laundry services; food preparation and delivery; biomedical waste removal, including contaminated items such as personal protective equipment; perimeter fencing; contracted security guards; professional cleaning; and other related services. The toolkit and other Alternate Care Site resources are available on the HHS website at https://asprtracie.hhs.gov/technical-resources/111/covid-19-alternate-care-site-resources.

MONITORING AND EVALUATION

FEMA will closely monitor the implementation of this policy through close coordination with regional and field staff, as appropriate, as well as interagency partners and SLTT stakeholders.

QUESTIONS

Applicants should direct questions to their respective FEMA regional office.

CDC Centers for Disease
Control and Prevention

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Coronavirus Disease 2019 (COVID-19)

Overview of Testing for SARS-CoV-2

Note: This document is intended to provide guidance on the appropriate use of testing and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency.

Revisions were made on June 13, 2020, to reflect the following:

Changes noted were made in a retired document, "Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)," which has been replaced by this Overview of Testing for SARS-CoV-2. See more changes.

This document provides a summary of considerations and current Centers for Disease Control and Prevention (CDC) recommendations regarding SARS-CoV-2 testing. The CDC recommendations for SARS-CoV-2 testing have been developed based on what is currently known about COVID-19 and are subject to change as additional information becomes available.

Recommendations for Viral Testing, Specimen Collection, and Reporting

Authorized assays for viral testing include those that detect SARS-CoV-2 nucleic acid or antigen. Viral (nucleic acid or antigen) tests check samples from the respiratory system (such as nasal swabs) and identify if an infection with SARS-CoV-2, the virus that causes COVID-19, is present. Viral tests are recommended to diagnose acute infection. Some tests are point-of-care tests, meaning results may be available at the testing site in less than an hour. Other tests must be sent to a laboratory to analyze, a process that may take 1-2 days once received by the lab. Testing the same individual more than once in a 24-hour period is not recommended.

For more information on diagnostic testing for COVID-19 see the Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens and Biosafety FAQs for handling and processing specimens from possible cases.

Recommendations for Antibody Testing

CDC does not currently recommend using antibody testing as the sole basis for diagnosis of acute infection, and antibody tests are not authorized by FDA for such diagnostic purposes. In certain situations, serologic assays may be used to support clinical assessment of persons who present late in their illnesses when used in conjunction with viral detection tests. In addition, if a person is suspected to have post-infectious syndrome (e.g., Multisystem Inflammatory Syndrome in Children) caused by SARS-CoV-2 infection, serologic assays may be used.

Serologic assays for SARS-CoV-2, now broadly available, can play an important role in understanding the transmission dynamic of the virus in the general population and identifying groups at higher risk for infection. Unlike viral direct detection methods, such as nucleic acid amplification or antigen detection tests that can detect acutely infected persons, antibody tests help determine whether the individual being tested was previously infected—even if that person never showed symptoms.

It is currently not clear whether a positive serologic test indicates immunity against SARS-CoV-2; serologic tests should not be used at this time to determine if an individual is immune. As additional data are collected to understand the significance of the presence or level of antibodies and their correlation with immunity, serologic tests may have utility in infection control decisions, but for now this evidence is not available.

These tests can help determine the proportion of a population previously infected with SARS-CoV-2. Thus, demographic and geographic patterns of serologic test results can help determine which communities may have experienced a higher infection rate.

Categories for SARS–CoV–2 Testing

This document describes five categories of people for SARS-CoV-2 testing with viral tests (i.e., nucleic acid or antigen tests):

- Testing individuals with signs or symptoms consistent with COVID-19
- Testing asymptomatic individuals with recent known or suspected exposure to SARS-CoV-2 to control transmission
- Testing asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification in special settings
- Testing to determine resolution of infection (i.e., test-based strategy for Discontinuation of Transmission-based Precautions, HCP Return to Work, and Discontinuation of Home Isolation)
- Public health surveillance for SARS-CoV-2

Generally, viral testing for SARS-CoV-2 is considered to be diagnostic when conducted among individuals with symptoms consistent with COVID-19 or among asymptomatic individuals with known or suspected recent exposure to SARS-CoV-2 to control transmission, or to determine resolution of infection. Testing is considered to be surveillance when conducted among asymptomatic individuals without known or suspected exposure to SARS-CoV-2 for early identification, or to detect transmission hot spots or characterize disease trends.

Recommended testing for individuals with signs or symptoms consistent with COVID-19

CDC recommends using authorized nucleic acid or antigen detection assays ↗ that have received an FDA EUA to test persons **with** symptoms when there is a concern of potential COVID-19. Tests should be used in accordance with the authorized labeling; providers should be familiar with the tests' performance characteristics and limitations.

Clinicians should use their judgment to determine if a patient has signs or symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough) but some infected patients may present with other symptoms as well. Clinicians are encouraged to consider testing for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2 depending on patient age, season, or clinical setting; detection of one respiratory pathogen (e.g., influenza) does not exclude the potential for co-infection with SARS-CoV-2. Because symptoms and presentations may be different in children, consider referencing the CDC guidelines for COVID in neonates and for multisystem inflammatory syndrome in children (MIS-C).

The severity of symptomatic illness due to infection with SARS-CoV-2 may vary. Among persons with extensive and close contact to vulnerable populations (e.g., healthcare personnel [HCP]), even mild signs and symptoms (e.g., sore throat) of possible COVID-19 should prompt consideration for testing. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19).

Recommended testing for asymptomatic individuals with known or suspected exposure to SARS-CoV-2 to control transmission

Testing is recommended for all close contacts 🗎 of persons with SARS-CoV-2 infection, especially initial testing during an outbreak or pandemic due to the high likelihood of exposure. Because of the potential for asymptomatic and pre-symptomatic transmission, it is important that contacts of individuals with SARS-CoV-2 infection be quickly identified and tested.

- In areas where testing is limited, CDC has established a testing hierarchy; refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan 🗎 for more information.
- CDC specifically recommends testing for all neonates born to women with COVID-19, regardless of whether there are

signs of infection in the neonate.

In some settings, broader testing, beyond close contacts, is recommended as a part of a strategy to control transmission of SARS-CoV-2. This includes high-risk settings that have potential for rapid and widespread dissemination of SARS-CoV-2 (e.g., meat processing plant) or in which populations at risk for severe disease (e.g., long-term care facilities, including nursing homes, intermediate care facilities for individuals with intellectual disabilities, and psychiatric residential treatment facilities) could become exposed. Expanded testing might include testing of all contacts in proximity to someone with SARS-CoV-2 infection, or even testing all individuals within a shared setting (e.g., facility-wide testing). Currently CDC recommends expanded contact testing in the following guidance documents:

- Testing guidance for nursing homes.
- Following identification of SARS-CoV-2 infection in a worker in a high-density critical infrastructure workplace

Recommended testing for asymptomatic individuals without known or suspected SARS‑CoV‑2 exposure for early identification in special settings

Certain settings can experience rapid spread of SARS-CoV-2, resulting in substantial adverse effects. This is particularly true for settings that house vulnerable populations in close quarters for extended periods of time (e.g., long-term care facilities, correctional and detention facilities) and/or settings where critical infrastructure workers (e.g., healthcare personnel, first responders) may be disproportionately affected.

A strategy aimed at reducing introduction of SARS-CoV-2 into the setting through early identification could reduce the risk of widespread transmission in these situations.

Facilities are encouraged to work with local, territorial, and state health departments to help inform decision-making about broad-based testing. Before testing large numbers of asymptomatic individuals without known or suspected exposure, the facility should have a plan in place for how it will modify operations based on test results.

Approaches for early identification of asymptomatic individuals include:

- Initial testing of everyone residing and/or working in the setting,
- Regular (e.g., weekly) testing of everyone residing and/or working in the setting, and
- Testing of new entrants into the setting and/or those re-entering after a prolonged absence (e.g., one or more days)

Settings for which these approaches could be considered include:

- Long-term care facilities
- Correctional and detention facilities
- Homeless shelters
- Other congregate work or living settings including mass care, temporary shelters, assisted living facilities, and group homes for individuals with intellectual disabilities and developmental disabilities
- High-density critical infrastructure workplaces where continuity of operations is a high priority

CDC guidance currently addressing such testing includes:

- Pre-admission or pre-procedure testing as part of the evaluation of patients could be considered to inform decisions about deferring elective care (e.g., certain dental procedures) or procedures and the use of personal protective equipment.

- Testing guidance for nursing homes

Recommended testing to determine resolution of infection with SARS-CoV-2

A test-based strategy, which requires serial tests, can be used as an alternative to a symptom-based or time-based strategy, to determine when a person with SARS-CoV-2 infection no longer requires isolation or work exclusion. This strategy could be considered in three situations:

- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings
- Discontinuation of Isolation for Persons with COVID -19 Not in Healthcare Settings
- Determining Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19

Public health surveillance for SARS-CoV-2

Testing is a fundamental part of the United States SARS-CoV-2 Surveillance Plan, which uses multiple surveillance systems and epidemiology networks, in collaboration with state, local, and academic partners, to monitor the progression and impact of SARS-CoV-2 spread in the United States.

Viral tests are used in community, outpatient, and hospital-based surveillance systems to identify cases of SARS-CoV-2 infection. These data help identify areas of ongoing circulation (hot spots), determine trends in disease by location, provide insight into the impact of the disease over time and by location, and inform disease forecasts.

Antibody tests are increasingly used to monitor disease burden by location and over time. Use of serologic assays in populations can help determine the proportion of a population previously infected with SARS-CoV-2. Thus, demographic and geographic patterns of serologic test results provide data that can be used in forecasts of disease spread that can support resource allocation decisions and planning by local, territorial and state officials.

Additional Resources:

- Nasal (Anterior Nasal) Specimen Collection for SARS-CoV-2 Diagnostic Testing 🔲 [1 page]
- Guidance – Proposed Use of Point-of-Care (POC) Testing Platforms for SARS-CoV-2 (COVID-19) 🔲 [2 pages]
- State health department after-hours contact list ↗
- Directory of Local Health Departments ↗
- World Health Organization (WHO) Coronavirus ↗
- WHO guidance on clinical management of severe acute respiratory infection when COVID-19 is suspected ↗
- NIH Coronavirus Disease 2019 (COVID-19) and Treatment Guidelines ↗
- CMS Guidelines ↗
- FAQs on Diagnostic Testing from the FDA ↗

Summary of Changes to Retired Document, "Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)"

Revisions were made on May 3, 2020 to reflect the following:

- Updated recommendations for testing, specimen collection, and reporting patients and reporting positive test results
- Specification of testing priorities

Revisions were made on April 27, 2020 to reflect the following:

- Updated priorities for testing patients with suspected COVID-19 infection

Revisions were made on March 24, 2020 to reflect the following:

- Updated priorities for testing patients with suspected COVID-19 infection

Revisions were made on March 9, 2020, to reflect the following:

- Reorganized the Criteria to Guide Evaluation and Laboratory Testing for COVID-19 section

Revisions were made on March 4, 2020, to reflect the following:

- Criteria for evaluation of persons for testing for COVID-19 were expanded to include a wider group of symptomatic patients.

Page last reviewed: June 13, 2020