COVID-19: EXPANDING HOSPITAL CAPACITY TOOLKIT

Early in the COVID-19 pandemic response, the Missouri Hospital Association published A Framework For Managing The 2020 COVID-19 Pandemic Response to help hospitals plan for and manage surges of COVID-19 patients. As the pandemic response continues, hospitals may be able to manage the volume of COVID-19 patients, however, when coupled with the resumption of elective surgeries and procedures; increased patient confidence with resuming health care activities; and changes in post-acute testing and tracing activities; the capacity within the hospital may become limited for periods of time. This document focuses on capacity building and patient throughput processes that the hospital may consider to continue to care for an increased volume of patient needs. While this document focuses on increasing physical capacity, workforce also will play a significant role. MHA offers considerations for maximizing workforce in the COVID-19 Surge Staffing Solutions Fact Sheet. The Centers for Medicare & Medicaid Services issued many waivers to increase flexibilities, as has the state, to aid in the COVID-19 pandemic response. This document does not cover the application of all waivers that reduce burden and increase flexibilities.

continued >>

Duty to Plan

Hospitals must develop plans for moving from conventional to contingency to crisis capacity. During a disaster or declared emergency, the goal is to remain in contingency status to the extent possible. Strategies for remaining in contingency capacity may include the following.

- ❑ **Ensure the data being entered into local, state and federal databases is accurate to provide well-informed decision-making.**
- ❑ **Cancel elective procedures and surgeries to increase capacity.**
- ❑ **Discharge or transfer appropriate patients earlier to home or less acute levels of care.**
- ❑ **Transfer less acute patients from medical surgical units to alternate care sites, with the assistance of case managers and discharge planners.**
- ❑ **Transfer post-acute and behavioral health patients from acute settings into other appropriate settings.**
- ❑ **Expand critical care capacity into areas, such as post-anesthesia care units, surgical suites and outpatient care units.**
- ❑ **Expand patient care areas to include hallways and private rooms.**
- ❑ **Expedite admissions to move patients from the emergency department to patient care units.**
- ❑ **Screen individuals seeking care using EMTALA-compliant methods, in coordination with EMS or other medical direction, to determine the most appropriate care setting, including an established alternate care site for less acute patients.**
- ❑ **Collaborate with hospitals inside and outside the catchment area to care for patients keeping beds occupied who could otherwise be cared for elsewhere.**

Hospitals

Hospitals have been preparing for and managing COVID-19 patient surges. The CDC Hospital Preparedness Assessment Tool is a resource that MHA highlighted early in the response planning process. Strategies to maximize capacity for patients requiring hospitalization for high acuity and critical care services are differentiated by metropolitan and rural geography.

- ❑ **Missouri hospitals and health systems in metropolitan areas may convert and expand capacity to the extent possible to staff and provide care for acutely and critically ill patients within their existing hospitals and campuses. All understand this may not be adequate and allocation of scarce resources may become a reality.**
  - Convert specialty units, such as post-anesthesia units, outpatient and surgical areas into critical care areas.
  - Convert medical-surgical units to high-acuity step-down units.
  - Expand into nonpatient care areas based on supplies, staff and functionality.
  - Establish alternate sites of care for screening, testing and ongoing care.

- ❑ **Missouri hospitals in rural areas, including critical access hospitals, may convert and expand to the extent possible to staff and provide care for acutely, critically ill and less acute patients within their existing hospitals and campuses. When feasible, rural facilities with additional capacity should be considered as a setting for caring for lower-acuity and post-acute patients from metropolitan areas.**
  - Rural hospitals without negative air flow capability should consider accepting and expanding capacity for non-COVID-19 patients.
  - In critical situations, COVID-19 patients should be segregated by space and staff from non-COVID-19 patients.
  - Hospitals with swing beds may increase swing bed designation and care for more patients unable to go to long-term care facilities or transition home for a period of time.
  - Establish alternate sites of care for screening, testing and ongoing care.

CMS also recently released the Rural Crosswalk: CMS Flexibilities to Fight COVID-19. Rural hospitals also have many resources available through the Rural Health Information Hub website. Specifically, the Rural Healthcare Surge Readiness page is a new section within the site. The section aims to provide the most up-to-date and critical resources for rural health care systems preparing for and responding to a COVID-19 surge.

- ❑ **Hospitals throughout Missouri are encouraged to plan regionally and make available collective resources to further expand hospital capacity. For example, pediatric hospitals may have lower census and the ability to accept pediatric and young adult patients from general acute care hospitals to create more capacity in those hospitals caring for acuity and critically ill. Long-term acute care hospitals also should be considered critical partners in caring for patients originating in the acute hospital environment.**

continued >>

- ❑ **Hospitals may need to consider postponing elective procedures on a case-by-case basis. MHA developed the Guidance for Cancellation of Elective Surgeries and Other Procedures document for hospitals experiencing patient surges or other circumstances related to the pandemic response where bed capacity is severely limited. This resource is intended to provide hospitals with critical factors to consider when deciding about the potential cancellation of elective surgeries and other procedures.**

  The goal is to consistently and transparently address patient care issues that Missouri hospitals and communities will continue to encounter during this COVID-19 pandemic. As cases of COVID-19 increase in communities, we must be diligent in our effort to protect patients, caregivers, practitioners and the community-at-large. When the crisis abates, MHA supports hospitals with the COVID-19: Guidance For Resuming Elective Procedures document.

Alternate Care Sites

In response to the COVID-19 public health emergency, state and local governments, hospitals, and others can develop alternate care sites to expand capacity and provide needed care to patients. The term alternate care site is a broad term for any building or structure that is temporarily converted or newly erected for health care use. Many acute care hospitals have established ACSs by converting existing nonclinical space for clinical use, as well as locations outside of the hospital such as tents, community buildings, hotels or other non-clinical locations. Hospitals already are enrolled in CMS programs and can treat these locations as a temporary extension of their existing hospital footprint during the PHE under flexibility granted through 1135 waivers. CMS pays for inpatient and outpatient care furnished in these ACSs as if the care had been delivered in the hospital's traditional "brick-and-mortar" locations. Hospitals must follow all applicable CMS coding and billing rules during the PHE.

The waivers do NOT, however, eliminate enrollment, survey and billing requirements for brand new hospitals that wish to furnish care to beneficiaries. CMS temporarily has modified physician supervision requirements, physical environment and telehealth payment policies to promote access to care during the PHE.

The following ACS resources exist to help hospitals considering the development of such sites.

- Fact sheet for local and state government establishing alternate sites of care
- CMS Hospitals: Flexibilities to Fight COVID-19
- MHA Waiver Tracking Sheet

Flexibilities with Swing Bed and Skilled Nursing Bed Utilization

Hospitals Without Swing-Bed Status

CMS has expanded the ability for hospitals to offer swing bed services for patients who do not require acute care but do meet the Skilled Nursing Facility level of care criteria as set forth at 42 CFR 409.31.

Under Section 1135(b)(1) of the Act, CMS has waived the requirements at 42 CFR 482.58, "Special Requirements for hospital providers of long-term care services ("swing-beds")" subsections (a)(1)-(4) "Eligibility," to allow hospitals to establish SNF swing beds payable under the SNF prospective payment system to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF. This waiver applies to all Medicare enrolled hospitals, except psychiatric and long-term care hospitals that need to provide post-hospital SNF level swing-bed services for non-acute care patients in hospitals, so long as the waiver is not inconsistent with the state's emergency preparedness or pandemic plan. The hospital cannot bill for SNF PPS payment using swing beds when patients require acute level care or continued acute care at any time while this waiver is in effect. This waiver is permissible for swing bed admissions during the COVID-19 PHE with an understanding that the hospital must have a plan to discharge swing bed patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.

Hospitals must call the CMS Medicare Administrative Contractor enrollment hotline to add swing bed services. The hospital must attest to CMS that:

- ❑ **They have made a good faith effort to exhaust all other options; (8/20/20)**
- ❑ **There are no SNFs within the hospital's catchment area that, under normal circumstances, would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 PHE;**
- ❑ **The hospital meets all waiver eligibility requirements; and**
- ❑ **They have a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier.**

continued >>

Hospitals With Swing-Bed Status and LTCF Skilled Nursing Beds
The three-day prior hospitalization for coverage of a SNF stay requirement is temporarily waived. This waiver provides temporary emergency coverage of SNF services without a qualifying hospital stay. In addition, it authorizes renewed SNF coverage for certain beneficiaries without first having to start and complete a 60-day "wellness period." This waiver will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from starting or finishing the 60-day "wellness period" that would have occurred under normal circumstances. If the patient has a continued skilled care need that is unrelated to the COVID-19 emergency, then the beneficiary cannot renew his or her SNF benefits under the Section 1812(f) waiver, as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60-day "wellness period."

MHA had hospitals ask if they could admit to skilled beds without ANY immediate inpatient hospitalization associated with the patient's care. A clarification by CMS indicates that there is no requirement for an inpatient stay of any length prior to skilled bed admittance if the patient meets the requirements for skilled care. Again, this is in effect for the current PHE.

Flexibilities for Long Term Acute Care Hospitals

CMS has waived the site-neutrality adjustment for admissions that are in response to the PHE. The waiver lifts certain penalties for LTCHs encouraging collaboration with the specialty hospitals to care for patients they may not otherwise normally admit and create additional capacity in the acute hospital.

Also as required by Section 3711(b) of the CARES Act, during the PHE due to COVID-19, the Secretary has waived Section 1886(m)(6) of the Social Security Act relating to certain site neutral payment rate provisions for LTCHs.

- **Section 3711(b)(1) of the CARES Act waives the payment adjustment under Section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a discharge payment percentage for the period that is at least 50% during the COVID-19 PHE period. Under this provision, for the purposes of calculating an LTCH's DPP, all admissions during the COVID-19 PHE period will be counted in the numerator of the calculation, that is, LTCH cases that were admitted during the COVID-19 PHE period will be counted as discharges paid the LTCH PPS standard Federal payment rate.**
- **Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site neutral payment rate under Section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the PHE and occur during the COVID-19 PHE period. Under this provision, all LTCH cases admitted during the COVID-19 PHE period will be paid the relatively higher LTCH PPS standard federal rate.**

Collaboration with Long Term Care Nursing Facilities

Hospital Transfers to LTCF
Hospitals and LTCF have spent a considerable amount of time wading through the regulatory requirements surrounding reporting and testing of COVID-19. Hospitals and facilities have developed their own interpretations, which were sometimes in conflict with one another. To help provide some clarity around patient transfers, MHA, Leading Age Missouri, Missouri Health Care Association and the Department of Health and Senior Services, collaborated to develop the following tools to be used when transferring patients from one care facility to another. Using guidance from the CDC and CMS, these forms capture pertinent information related to a patient's COVID-19 status to expedite transfers, keep patients and health care staff safe and informed, and reduce inappropriate testing requests prior to acceptance.

- Hospital to Facility Transfer Form
  - Video vignette to educate hospitals and LTCF on the science behind the form and the appropriate use.
- Post-Acute Care and Behavioral Health to Hospital Transfer

These tools should be:

- **completed by the health care team with the signature of the provider overseeing care**
- **provided to the facility as part of the inquiry for discharge placement**
- **used regardless of COVID-19 diagnosis while in the hospital**
- **provided to EMS**

The Missouri Department of Health & Senior Services can provide direction if a facility is refusing to take back a patient after transferring that patient to the hospital; however, DHSS cannot require a facility to accept new admissions. A facility may refuse new admissions for a variety of reasons, including an internal event or upon direction from the department. Hospitals can contact Shelly Williamson, shelly.williamson@health.mo.gov, or Tracy Niekamp, Tracy.Niekamp@health.mo.gov, with concerns related to a specific facility, or call 573-526-8524.

continued >>

LTCF Transfers of COVID-19 Patients
A long-term care facility can temporarily transfer its COVID-19 positive residents to another facility, such as a COVID-19 isolation and treatment location, with the provision of services "under arrangements." The transferring LTCF need not issue a formal discharge in this situation, as it is still considered the provider and should bill Medicare normally for each day of care. The transferring LTCF is then responsible for reimbursing the other provider that accepted its resident(s) during the emergency period. If the LTCF does not intend to provide services under arrangement, the COVID-19 isolation and treatment facility is the responsible entity for Medicare billing purposes. The SNF should follow the procedures described in 40.3.4 of the Medicare Claims Processing Manual to submit a discharge bill to Medicare. The COVID-19 isolation and treatment facility should then bill Medicare appropriately for the type of care it is providing for the beneficiary. If the COVID-19 isolation and treatment facility is not yet an enrolled provider, the facility should enroll through the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area to establish temporary Medicare billing privileges. This is an opportunity for hospitals to collaborate with and encourage LTCF in their region to establish such facilities/locations and models to improve timely transitions.

General Resources

COVID-19 Frequently Asked Questions on Medicare Fee-for-Service Billing