Designation of Skilled Nursing Facilities or Units to Serve COVID-19 Positive Residents

The Tennessee Department of Health (TDH), with the assistance of TennCare, seeks to designate certain Skilled Nursing Facilities (SNFs) or certain areas within SNFs as COVID-19 Skilled Care Centers (CSCCs) or COVID-19 Skilled Care Units (CSCUs) during the COVID-19 Public Health Emergency (PHE). Nursing home residents who become COVID-positive and cannot be well-isolated in their facilities could be transferred to CSCCs/CSCUs, hopefully reducing spread within high-risk populations living in close proximity. The Centers for Medicare and Medicaid Services (CMS) has recommended that States establish such facilities or units and has temporarily waived certain federal regulations pertaining to resident admission, discharge, and transfer rights in order to facilitate transfer of residents to such facilities or units temporarily. In addition, and particularly as it relates to surge capacity planning, patients ready for discharge from hospitals but requiring post-acute care who have been confirmed COVID-positive until safe to return to the general resident population.[1] Hospitals have identified this capacity as an urgent need.

Levels of Care and Payment

There will be two levels of care in CSCCs/CSCUs.

- Level I would provide care to asymptomatic COVID-19 positive residents and minimally symptomatic COVID-19 positive residents, including all COVID-19 positive residents who do not have respiratory care needs that qualify for Level II CSCC/CSCU care and reimbursement. The vast majority of COVID-positive residents would need Level I care.
- Level II would provide care to more complex COVID-19 positive residents, such as tracheostomized and mechanically ventilated residents – those who would meet Medicaid medical eligibility criteria for Enhanced Respiratory Care (ERC) reimbursement,[2] and also have a COVID-19 diagnosis. Higher standards of care would apply, commensurate with both the higher level of care required by these residents, and the higher level of Medicaid payment provided for ERC services.

[1] These discharging patients would need to qualify for the level of care provided in a SNF/NF in order to be eligible for Medicare or Medicaid payment, as applicable. The same is true for commercial payers.

[2] Enhanced Respiratory Care (ERC)—specialized types of assistance provided to individuals with certain significant respiratory care needs as part of the medically necessary services delivered in an appropriately licensed and dual certified NF/SNF, consisting of Ventilator Weaning, Chronic Ventilator Care, or Tracheal Suctioning including Sub-Acute and Secretion Management, and for which a NF may be eligible to receive ERC Reimbursement through the TennCare program. In the Medicaid ERC Program, the ERC payment is an add-on payment to the existing Medicaid per diem based on the higher level of care required by ERC patients, and the higher cost facilities are expected to incur in providing that care. Standards of care prescribed in TennCare Rule are a condition of eligibility for Medicaid ERC reimbursement and help to ensure that the expected level of quality care is in fact provided. The Board for Licensing Health Care Facilities has adopted comparable standards of care for purposes of licensing facilities who provide ventilator care.

We will begin by establishing up to 13 Level I facilities in each of the following urban areas:

- Chattanooga
- Clarksville
- Jackson
- Knoxville
- Memphis
- Nashville
- Tri-Cities

The number of facilities/beds will be based on the population base in each area, with the highest concentration in Nashville and Memphis. We will also seek to establish at least one Level II facility—centrally located—and add capacity as needed.

Funding

A higher level of payment as well as start-up funding will be needed to establish and provide care in CSCCs/CSCUs—to cover higher costs of equipment, supplies (including, but not limited to PPE), and staffing, and to offset the lost revenue facilities may incur in holding these beds for COVID patients.

TennCare is the primary payer of nursing home care—60-65%. Medicare generally accounts for 11-15% of total revenue for these facilities, with the balance (20-25%) comprised of commercial insurance, private pay and/or uninsured. Medicare is typically the primary payer for up to 100 days after a member has been discharged from a hospital—so long as the person meets Medicare skilled care requirements. CMS has temporarily waived the 3-day prior hospital stay requirement to qualify for Medicare SNF services under Medicare Part A for those people who experience dislocations or are otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, CMS waivers authorize renewed Part A SNF coverage without first having to start a new benefit period such that a new 100-day benefit period could begin (this waiver applies only for beneficiaries who have been delayed or prevented by the PHE itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances).[3]

The Medicare Patient Driven Payment Model (PDPM)[4] takes into account clinically driven COVID-19 related needs and provides a significantly higher Part A payment for COVID-positive residents (when COVID-19 is the primary diagnosis or based on acuity-related needs such as therapies, nursing, respiratory care, etc. reflected on the MDS). We expect the Medicare payment to be sufficient to cover these costs when Medicare is the payer source. TennCare cannot supplant

[3] See https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.

[4] PDPM is a case-mix classification model, encompassing therapies (physical, occupational and speech), nursing and non-therapy ancillary services that is used to drive prospective payments in Medicare Part A.

Medicare as the primary payer of these services, nor supplement the Medicare payment (beyond established processes for coverage of Medicare co-insurance). Additional payment would be needed for Medicaid residents, for commercial/private pay and for uninsured individuals.

SNFs selected for designation and contracted as CSCCs/CSCUs will be required to meet certain standards of care to be eligible for these additional COVID-related payments.

Data-Based Designation of CSCCs/CSCUs

CSCCs/CSCUs will be selected for designation as CSCCs/CSCUs based on their capacity to deliver these services using a data-driven approach and their willingness to provide these services and meet CSCC/CSCU standards of care. As the primary payer of nursing home services, TennCare will operationalize the CSCC/CSCU selection and contracting process on behalf of TDH except for reimbursement of start-up costs, which TDH will manage directly.

TennCare collaborated with contracted Managed Care Organizations and with Eventa®, LLC, a company of nationally recognized experts in the field of enhanced respiratory care, to develop a data-driven approach for the selection and designation of CSCCs and CSCUs in Tennessee. We reviewed approaches in other states, as well as other public health policy research and recommendations, including primarily those developed with funding from the Agency for Healthcare Research and Quality (Grant No. U19 HS24072).[5]

Based on these discussions and research, TennCare has adopted an objective data-based approach to the identification and designation of Level I CSCCs a "COVID-19-Capability Scorecard," as developed by Dafney and Lee.[6] The Scorecard is comprised of five measures:

1. Demonstrated skill and some existing staff trained to care for patients with respiratory distress and other related complications;
2. Relatively few long-term residents who might require relocation;
3. Significant potential capacity, so care can be provided at scale and isolation of residents without COVID-19 (and who cannot be relocated) is more feasible;
4. High operational readiness; and
5. High-quality management.

[5] *"Designating Certain Post-Acute Care Facilities As COVID-19 Skilled Care Centers Can Increase Hospital Capacity And Keep Nursing Home Patients Safer, "* Health Affairs Blog, April 15, 2020. DOI: 10.1377/hblog20200414.319963

[6] The scorecard is available at: https://www.hbs.edu/covid-19-business-impact/Topics/Health-Care-Management-and-Policy/COVID-19-Skilled-Care-Center-Scorecard.

For each measure, an existing data source is identified as a proxy in order to ease and expedite the identification process. These are derived from Medicare claims data or Medicare's Nursing Home Compare database.

Measure	Proxy
Demonstrated skill and some existing staff trained to care for patients with respiratory distress and other related complications	Share in COVID-adjacent DRGs[7]
Relatively few long-term residents who might require relocation	Share short-stay[8]
Significant potential capacity, so care can be provided at scale and isolation of residents without COVID-19 (and who cannot be relocated) is more feasible	Total beds
High operational readiness	Nursing hours per patient day
High-quality management	Overall quality rating

The Scorecard leverages existing data sources to gather a limited set of data from every SNF to identify the best candidate facilities. Eligible facilities are ranked for each of the metropolitan areas listed above.

Of note, the Scorecard excludes certain facilities, including those operating as swing-beds for hospitals, containing a retirement community, or having fewer than 50 beds (to further avoid risk of spread or to ensure sufficient capacity to serve COVID-19 positive residents). It also excludes SNFs rated a 1 on the 5-star scale for "overall quality" under the SNF Five-Star Quality extended pattern of violations.

TennCare will work with MCO partners and Eventa to review each of the 12 facilities self-identified in the survey conducted by the Tennessee Health Care Association (THCA), based on their scorecard performance, also taking into account facilities' performance on the Medicare Five-Star Quality Rating System, including (but not limited to) survey inspections, as well as any financial concerns related to the timely payment of NF assessment fees (which may be indicative of broader financial or quality concerns or pose additional challenge when serving as a CSCC/CSCU).

[7] The share of each SNF's short-stay Medicare admissions accounted for by patients discharged from the hospital under DRGs (Diagnosis Related Groups, Medicare's payment categories) that span the most common ICD-10 codes for respiratory illness, coronavirus (non-COVID), and flu viruses, as well as DRGs for all other respiratory and infectious diseases

[8] Facilities with higher rates of short-stay occupancy could better position themselves to become CSCCs/CSCUs by declining new patients and isolating or relocating longer-stay patients.

In the event the most capable facilities have not self-identified, TennCare will use a comparable approach to identify and target facilities for potential designation as CSCCs/CSCUs, subject to their interest and willingness to provide this care, and to meet required care standards.

Level II CSCCs/CSCUs would be identified and designated from among facilities currently licensed and contracted to provide Medicaid Enhanced Respiratory Care Services in SNFs.

CSCC/CSCU Standards of Care

To be contracted as CSCC/CSCU facilities and eligible for the enhanced COVID payment for Medicaid NF residents and commercial/private pay or uninsured individuals, SNFs must meet certain standards of care, including physical, staffing, equipment, and policy requirements as follows:

Physical Requirements

- The facility/unit is dually certified for participation in both the Medicare and Medicaid programs.
- If non-COVID patients will also be residents of the facility:
    - There are designated halls, wings, and/or floors for treatment of COVID-19 residents.
    - There are designated resident restrooms and showers for each area.
    - There are designated zones to minimize exposure for different risk groups, as follows:
        - Green zone – symptom free, no exposure
        - Yellow zone, private rooms, full PPE required – new admissions or hospital readmissions, regular dialysis recipients, probable or confirmed exposure to COVID-19 (but have not tested positive for COVID-19)
        - Red zone – COVID-19 positive
    - There are separate entrances/exits for each designated zone and a separate time clock for employees working in each designated zone.[9]
    - There are designated staff areas in each zone: nurses' station, restrooms, breakrooms, etc.There is a designated cleaning area for equipment.
- Level II only: The facility must meet NFPA-99 requirements/Life Safety approval.

[9] Separate entrances/exits are recommended by AHCA https://www.ahcancal.org/facility_operations/disaster_planning/Documents/Cohorting.pdf; however, we recognize this could increase elopement concerns or may pose significant structural barriers. For this requirement only (i.e., separate entrances/exits and time clock), facilities may propose alternative approaches to achieve the underlying goal of minimizing risk of exposure among facility staff for review/approval by the approving entity.

Staffing Requirements

- There are dedicated RNs and LPNs for each zone (nurses may not work in more than one zone).
- There are dedicated CNAs for each zone (CNAs may not work in more than one zone).
- There are dedicated skilled therapists for each zone (therapists may not work in more than one zone).
- There are dedicated environmental services (housekeeping) staff for each zone.
- There is at least one staff member dedicated to infection prevention and control and auditing/monitoring PPE use, hand hygiene, and environmental services.
- The use of staffing agencies is strongly discouraged (due to potential exposure; however, if essential, may be approved, subject to ongoing mandatory screening and testing of staffing agency staff).
- Staff are paid at a "hazard pay rate," i.e., at least $5/hour above traditional facility wages for staff at this qualification level.
- Level I: At least one Respiratory Therapist is onsite 7 days/week (minimum 8 hours/day).
- Level II: At least one Respiratory Therapist is onsite 24 hours/day (in addition to other staffing requirements applicable for ERC facilities).

Equipment Requirements (for yellow and red zones)

- There is a designated stethoscope, blood pressure cuff, vital signs machine, and thermometer for each resident, or for each zone with appropriate cleaning of each device between patients in the zone.
- There is at least one (more if needed, depending on volume) designated crash cart for each zone.
- There is a designated lift for each zone.
- There are designated shower chairs for residents in each zone.
- There is designated pulse oximetry (medical grade) with ear probe capability in each zone.
- There is a designated Metered Dose Inhaler (MDI) with a spacer for each person requiring aerosolized medications.
- There are designated oxygen concentrators (5L and 10L concentrators) for each person requiring such equipment.
- There are designated cleaning carts and other cleaning supplies for each area.
- PPE supply and adherence for all patient interaction: gloves, goggles/faceshield—either surgical mask (masking the resident while in the room as well) or N95; gown (disposable or reusable-for each resident encounter); and shoe covers when there is a risk of splashing from infected body fluids.
- There are alcohol-based hand sanitizers accessible in all resident-care areas (including inside and outside resident rooms).

- Level II CSCCs/CSCUs will also have the following designated devices when needed:
    - CPAP and BiPAP devices;
    - Heated, high flow humidification devices;
    - End-tidal capnography device;
    - Cough Assist and HFCWO devices (only when absolutely necessary); and
    - Remote monitoring system.

Policy Requirements

- The facility establishes and complies with written admission criteria.
- The facility establishes and complies with written policies regarding Code Status (DNR) or POST (including DNI) form advance planning discussions with each COVID-positive resident or authorized health care decision maker prior to admission.
- The facility establishes and complies with written transfer to acute care criteria, taking into account advance planning discussions and directives.
- The facility establishes visitor restriction policies according to current state and CMS guidelines.
- The facility establishes an infection prevention program that includes a written infection control plan that outlines strategies, policies, procedures and a quality assurance process with oversight for prevention of transmission of COVID19 within the facility.
- Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities.
- The facility has a detailed plan for testing and management of residents who develop symptoms or are suspected of having COVID-19. This includes having the ability to rapidly identify contacts of confirmed cases and obtain testing.
- The facility establishes an employee respiratory protection program according to OSHA standard 1910.134 for staff who will wear respirators. The facility establishes and complies with sick leave policies for staff/employees. Policies are flexible and non-punitive.
- Resident vitals screening is conducted every 4 hours (HR, Respiration, SpO2, BP, temperature)—in yellow and red zones.
- Resident screening for malnourishment and dehydration is conducted by a Registered Dietitian.
- Employee vitals screening is conducted on every shift.
- Employee COVID-19 testing is routinely conducted at an interim determined by TDH to be appropriate (every 7, 10, or 14 days is suggested for consideration).
- There are established communication processes (including necessary equipment) for the CSCC/CSCU to share information with residents and families, and for residents and families to communicate with one another.

In addition to these standards, a Level II CSCC/CSCU would be required to meet ERC standards of care, as prescribed in TennCare Rule.[10] Given the level of expertise required, preference should be given to existing ERC facilities, particularly facilities in the higher tiers of quality performance as measured through the TennCare Quality Improvement in Long-Term Services and Supports (QuILTSS) ERC Initiative. We further recommend careful review of the volume of Level II capacity needed, with the potential that one statewide Level II CSCC or CSCU may be sufficient, or perhaps one Level II CSCC or CSCU per region.

Payment for CSCCs/CSCUs

TDH would provide up to $250,000 per facility selected for designation as a CSCC/CSCU to help defray documented start-up costs. Upon implementation of contract with TDH, facility would submit a plan for approval by TDH, and approved costs would be reimbursed upon submission of an invoice to TDH for such payment.

Once operational and contracted, CSCCs/CSCUs will receive an *additional* payment of $300/day—a COVID+ adjustment—for each COVID-19 positive resident requiring isolation for whom Medicare is not the payer (i.e., Medicaid, commercial/private pay, and uninsured)[11] Medicaid and state-funded payments would be provided through the end of calendar year 2020, in accordance with CARES funding stipulations, with intent of continuation as additional funds are identified. CSCCs/CSCUs will not receive an additional payment for residents who are paid by Medicare.

The COVID+ NF adjustment would apply during the period the person requires isolation for COVID-19, and would end once isolation is no longer warranted, based on CDC guidelines, as they are updated. The payment would be limited to no more than 21 days, but could be extended up to a total of no more than 30 days (inclusive of the first 21 days) with explicit physician order and justification regarding why continued isolation is needed.

Medicaid payment for NF services (including the $300 COVID+ per diem adjustment) would be available only when person is served in a CSCC or CSCU contracted to provide these services and which complies with all applicable standards of care and only when Medicare payment has been exhausted.

[10] See TennCare Rule 1200-13-02-.04 at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-02.20180730.pdf.

[11] The current average Medicaid payment for NF services is $217.56/day. For residents with Enhanced Respiratory Care needs, the Medicaid rate for ventilator dependent patients provides already provides up to an additional $600/day (in addition to the NF's per diem). The $300/day COVID payment would be an additional payment (i.e., added to the facility's Medicaid rate, or in the care of patients qualifying for ERC, the facility's Medicaid rate AND ERC add-on payment) to account for the higher acuity of COVID-positive residents.