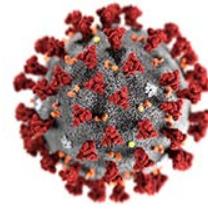


Hospital-Related COVID-19 Frequently Asked Questions September 2020



There has been a variety of hospital-related questions about COVID-19 asked by policymakers and the public, either directly or through social media. These FAQs help to address many of those hospital-related questions.

Q1. Are patient deaths attributed to COVID-19 if the patient was admitted to the hospital for another reason?

A1. Death certificates, which are completed by physicians, follow a very specific protocol for explaining the cause of death. Doctors must first indicate the immediate cause of death. In a patient with COVID-19, the cause of death is often hypoxic respiratory failure (not enough oxygen in your blood). The physician must then indicate what caused the respiratory failure, which for this example, would be acute respiratory distress syndrome (fluid build-up in the lungs). The doctor must then list the cause of the acute respiratory distress syndrome, which in this example, is COVID-19.

Doctors may also fill out a section for other significant conditions contributing to death but not resulting in the underlying cause of death. In the example above, the underlying conditions could include things like hypertension or diabetes.

In the case of a person admitted to the hospital after having a heart attack or being in a car accident, and then tested positive for COVID-19 and later died, the death certificate would be very specific as to the immediate cause of death. Whether or not COVID-19 was a direct contributing factor or just an underlying condition that did not cause the death, COVID-19 should be noted in the death certificate.

Q2. Could hospitals make more money by reporting patients as COVID-19 patients?

A2. The Medicare program added an additional 20% weighting to inpatient hospital payments for COVID-19 patients.

The added payment is conditional upon specific criteria. Prior to Sept. 1, 2020, hospital inpatients with a specific set of conditions related to COVID-19, as defined in Medicare diagnostic related groups, were classified as COVID-19 patients. Beginning Sept. 1, 2020, COVID-19 hospital inpatients must have a positive COVID-19 test. This precludes hospitals from reporting any patient as a COVID-19 patient without meeting those criteria.

These enhanced payments apply only to Medicare. The Medicare program pays approximately 85% of the allowable costs of care as determined by the program. This means that even with the rate enhancement, hospitals are not “making money” from Medicare COVID-19 patients, although there is some addition payment for a patient with COVID-19.

This “enhanced” reimbursement from Medicare only minimally offsets the increased costs of treating COVID-19 positive patients and upgrading hospitals to treat COVID-19 patients. It also does not offset the sharp declines in revenue hospitals experienced due to reducing elective procedures in anticipation of increased COVID-19 patients during the spring of 2020.

Q3. Are hospitals still concerned about personal protective equipment (PPE)?

A3. Yes. While most hospitals in Kansas have sufficient PPE to address the number of COVID-19 patients they are treating, some are still struggling to find enough PPE to go back to providing care at the regular rate for non-COVID-19 patients who still need to go to the hospital for care. The costs for PPE have gone up 4 to 5 times the pre-COVID-19 rate. All hospitals are watching PPE supplies very closely as flu season approaches, and COVID-19 numbers remain steady in the state.

Q4. The KDHE website numbers show there are plenty of ICU beds available. Why is everyone so concerned about the number of beds?

A4. There are several reasons to pay close attention to ICU bed availability across the state. First, COVID-19 patients aren't the only ones using ICU beds. In fact, as of Sept. 8, of the 384 ICU beds in use, only 51 are being used by COVID-19 patients. The pandemic did not stop traumas from occurring around the state. Second, flu season is approaching. The worst flu cases end up in the ICU as well, which may strain capacity. Third, ICU beds (and all hospital beds for that matter) must be staffed appropriately. Hospitals may need to change staffing and reschedule procedures if ICU beds reach capacity. If there are many health care workers ill or quarantine, hospitals may not be able to staff all of the ICU beds available.

Q5. Why are hospitals still limiting visitors when it's safe to go to restaurants and stores?

A5. Unlike restaurants and stores, where most of the people you encounter are healthy, hospitals have high concentrations of persons who are vulnerable to COVID-19. Hospital staff must be in close proximity to patients to provide care. The limitations on visitors are intended to protect patients and staff from infection, which in turn helps maintain the health care safety net for all Kansans. However, Kansas hospitals are working to help families maintain contact with their loved ones when only limited visitation is possible.

Q6. Hospitals received millions of dollars from the federal government for COVID-19. Why do we continue to hear that hospitals are losing money?

A6. Kansas hospitals voluntarily rescheduled many procedures that were not life-threatening to ensure that as COVID-19 entered Kansas that hospitals would be able to take care of COVID-19 patients. The result was a significant loss in revenue for hospitals. While hospitals have been able to reschedule those appointments, those losses have not been recouped as patients are slow to return due to fears over COVID-19 and lost income and insurance. In addition, hospitals spent significant amounts of money to purchase the necessary PPE at inflated prices, purchase equipment and repurpose space to address COVID-19 patient needs. This has left hospitals with declining revenues and increasing costs that will be difficult to overcome as the pandemic continues into the fall and winter.