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Swing Bed Reimbursement in Critical Access Hospitals

March 19, 2015
2:30 p.m. CT

Kristine Sande, Moderator

Presenters

Brock Slabach

National Rural Health Association

Kristin Reiter

Sheps Center for Health Services
Research, University of North Carolina

Susan Starling

Marcum and Wallace Memorial Hospital

Presentation

- Q & A to follow – Submit questions using Questions section of your control panel
- Slides are available at <http://www.raconline.org/webinars/swing-bed-reimbursement-in-cahs>

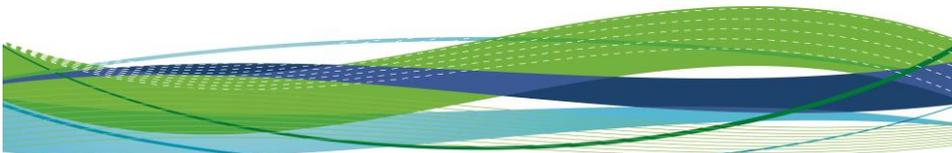


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Understanding Swingbed Reimbursement in Critical Access Hospitals

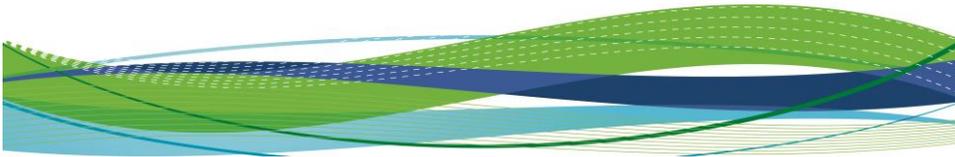
Brock Slabach, MPH, FACHE
Senior Vice President for Member Services
National Rural Health Association



Agenda



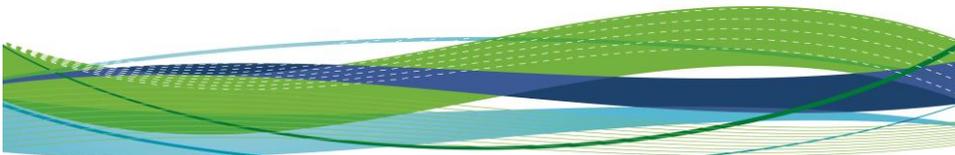
- Setting the Historical Context
- Review of the OIG Report
- Medicare, Swing Beds, and CAHs:
A Research Study
- Swingbeds: A View from the Field
- Payment Policy in the Current Context



Background



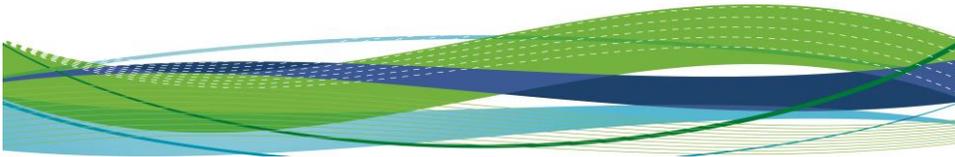
- Critical Access Hospitals (CAHs) were authorized by the Balanced Budget Act (BBA) of 1997.
- The CAH program was intended to improve the financial viability of small, rural hospitals that would be negatively affected by Medicare's Inpatient Prospective Payment System.
- By reimbursing CAHs for Medicare services on the basis of costs, the law aimed to cease closures of these hospitals and maintain access to care in isolated areas.



Background



The swing bed program was authorized in the Omnibus Reconciliation Act of 1980 to expand access to long-term care and post-acute skilled nursing services for individuals living in rural America and to maximize the efficiency of small and rural hospitals (ORA 1980).

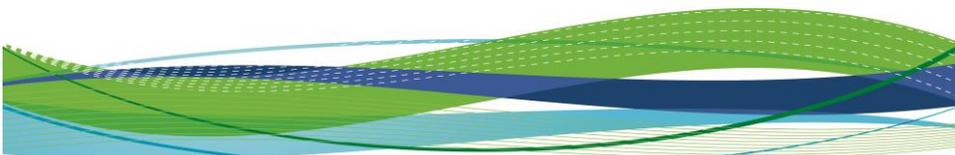


Background



Medicare beneficiaries are eligible for up to 100 days of skilled nursing services following a minimum 3-day acute inpatient hospitalization. These services are provided in freestanding skilled nursing facilities, hospital-based skilled nursing facilities, and hospital swing beds

(Title 42 U.S. Code, 2011).



Availability of post-acute skilled care varies by rural county size



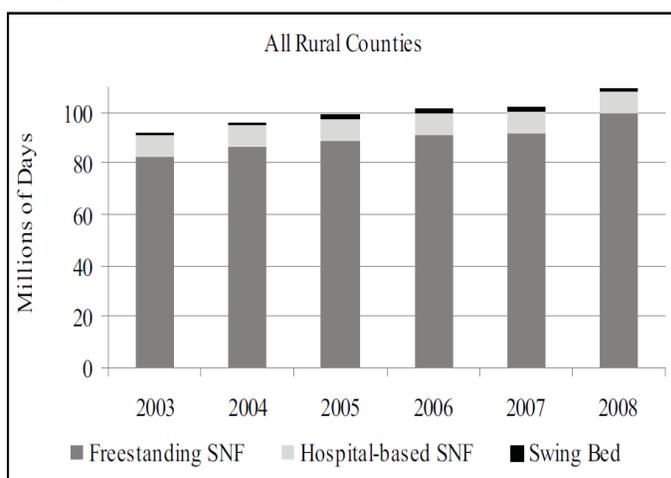
Micropolitan counties in 2008

- 95% of micropolitan counties had SNFs and 45% had both SNFs and swing beds
- Swing beds were the only skilled care providers in 0.6% of micropolitan counties
- 4% of micropolitan counties had no post-acute skilled care

Non-CBSA counties in 2008

- 80% of non-CBSA counties had SNFs and 55% had both SNFs and swing beds
- Swing beds were the only skilled care providers in 8.3% of non-CBSA counties
- 11% of non-CBSA counties had no post-acute skilled care

Post-acute skilled care days are dominated by care in community-based SNFs



Source: NCRHRC analysis of CMS Hospital Cost Report Information System, 6-30-10



Medicare, Swing Beds, and Critical Access Hospitals

Medical Care Research and Review.
(2013). 70(2): 206-17.

Kristin L. Reiter, George M. Holmes,
and Ila H. Broyles

March 19, 2015

*This work is partially funded by federal Office of Rural Health
Policy, Award #U1GRH07633*

Swing-Bed Cost Accounting Rules

“To calculate the cost of a post-acute patient’s routine care, **CMS divides the hospitals’ total inpatient routine costs (after carving out nursing-facility-type Medicaid days) by the sum of acute and post-acute days to obtain an estimated routine cost per day.** Because hospitals’ routine costs per day exceed freestanding SNFs’ routine costs per day, this change in payment method significantly increases payments for post-acute swing-bed patients.

Compared with the old payment method, the new one decreases payments for acute care. The changes reflect a shift in cost allocation from acute to post-acute care. To compute the routine costs allocated to acute patients, CMS starts with total inpatient routine costs and then “carves out” nursing-facility-type Medicaid payments. CMS then evenly allocates the remaining routine costs to acute and post-acute patients. Because costs allocated to post-acute payments increase under the new method, the costs remaining to be allocated to acute patients decrease. **Although CAHs receive roughly \$1,000 in Medicare payments for every post-acute day, the reduction in costs allocated to acute patients offsets some of that gain. For the marginal post-acute day, the net increase in Medicare payments may be only \$400 or \$500 instead of the full \$1,000.** Net revenue per post-acute day of \$400 or \$500 is \$100 to \$200 more than SNF payment rates of roughly \$300 per day.”

Medicare Payment Advisory Commission. “Report to the Congress: Rural Payment Provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003” (December 2006). Page 12. Available at: http://www.medpac.gov/documents/reports/Dec06_Rural_hospital_mandated_report.pdf?sfvrsn=0 (Accessed: March 12, 2015).

Medicare Reimbursement for Routine Inpatient Care in CAHs

Hospital cost per diem		# of Medicare days
Total inpatient routine cost less Swing NF Medicaid Cost* <hr style="width: 80%; margin: 5px auto;"/> # of acute + swing SNF + obs days	X	Acute + swing SNF days

* Reimbursed by Medicaid



A simplified example



Let's say 2 families (a family of 2 and a family of 4) rent a fishing boat for a day and decide to divide the cost equally per person. The total cost to rent the boat is \$840 regardless of the number of passengers. With 6 people, the cost per passenger is $\$840/6 = \140

Family 1 has 2 people



\$140 \$140

Total cost for family 1
 $\$140 \times 2 = \280

Family 2 has 4 people



\$140 \$140 \$140 \$140 \$140

Total cost for family 2
 ~~$\$140 \times 4 = \560~~
 ~~$\$140 \times 3 = \420~~



A simplified example



Let's say 2 families (a family of 2 and a family of 4) rent a fishing boat for a day and decide to divide the cost equally per person. The total cost to rent the boat is \$840 regardless of the number of passengers. **With 5 people, the cost per passenger is \$840/5=\$168**

Family 1 has 2 people



\$168 \$168

Total cost for family 1

$\$140 \times 2 = \280

$\$168 \times 2 = \336

Family 2 has 3 people



\$168 \$168 \$168

Total cost for family 2

$\$140 \times 4 = \560

$\$140 \times 3 = \420

$\$168 \times 3 = \504



\$140

The cost to family 1 goes up

The savings to family 2 is only \$56, not \$140

Why? The fixed cost of the boat rental is spread over fewer people.

A simplified example



Now say instead of a boat rental, the fixed cost is routine inpatient care. Family 1 is non-Medicare payers. Family 2 is Medicare. The three people from family 2 that remain in the boat are the acute days. The one that stays home is swing-beds.

Non-Medicare Days



\$168 \$168

Total cost

$\$140 \times 2 = \280

$\$168 \times 2 = \336

The cost of non-Medicare days goes up

Medicare Acute Days



\$168 \$168 \$168

Total cost

$\$140 \times 4 = \560

$\$140 \times 3 = \420

$\$168 \times 3 = \504

The cost of each acute day goes up.

Thus, the savings to Medicare is:

$\$140 - [(\$168 - \$140) \times 3] - \text{swing PPS rate}$

Medicare
Swing Days



\$140

Aim of Our Study

- ▶ To estimate the cost to Medicare for a CAH swing-bed day AFTER accounting for the transfer of fixed costs from swing-beds back to acute care



Recalculate Medicare reimbursement for routine inpatient care if **swing days = 0**

Hospital cost per diem	X	Medicare days
Total inpatient routine cost		# of acute + swing SNF days
– Swing NF Medicaid Cost		– Medicare swing SNF days
– Medicare swing marginal cost		
<hr/>		
# of acute + swing SNF + obs days –		
Medicare swing SNF days		



Implied Medicare Expenditure on a Swing-Bed Day

Medicare reimbursement for routine inpatient care with swing beds

Less

Medicare reimbursement for routine inpatient care without swing beds

■ Medicare "Savings"

Medicare Savings / # of Medicare swing SNF days =

Implied Medicare expenditure on a swing bed day



What We Found

In 2009:

- ▶ Average marginal (variable) cost of a swing bed day = **\$262**
- ▶ Implied Medicare expenditure on a swing bed day = **\$581**
- ▶ Average routine inpatient per diem cost with swing bed days = **\$1,302**
- ▶ Average increase in routine inpatient per diem cost without swing bed days = **\$721**



Estimating Medicare Savings from a Change in Payment Method

Using OIG assumptions

$\$1,302 - \$264^* = \$1,038$ per day

*\$264 is the average PPS payment for post-acute care from the OIG report

Accounting for fixed cost transfers

$\$581 - \$264^* = \$317$ per day

*\$264 is the average PPS payment for post-acute care from the OIG report

Note: These are only estimates. Actual savings to Medicare would depend on implementation of the formula, and the amount of variation across hospitals in the implied Medicare expenditure per swing bed day.



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Conclusion

- ▶ Important to differentiate between:
 - ▶ Marginal cost (variable cost)
 - ▶ Average reimbursement (per diem = average of costs for all types of inpatient days including swing)
 - ▶ Marginal reimbursement (change in per diem resulting from addition/exclusion of swing bed days from the per diem calculation)
- ▶ Important to recognize that changes in payment policy will affect hospitals differently depending on:
 - ▶ Relative mix of swing versus acute days
 - ▶ Medicare share of swing and acute days



For More Information

- Kristin L. Reiter and G. Mark Holmes. A Critique of the OIG's March 2015 Report on Swing Beds in Critical Access Hospitals, NC Rural Health Research Program, University of North Carolina, Policy Brief, March 2015
- Victoria A. Freeman, Randy K. Randolph, and G. Mark Holmes. Discharge to Swing Bed or Skilled Nursing Facility: Who Goes Where? North Carolina Rural Health Research and Policy Analysis Center, Findings Brief, February 2014.
- Victoria A. Freeman and Andrea Radford. Why Use Swing Beds? Conversations with Hospital Administrators and Staff, North Carolina Rural Health Research and Policy Analysis Center, Findings Brief, April 2012.
- Kristin L. Reiter and Victoria A. Freeman. Trends in Skilled Nursing Facility and Swing Bed Use in Rural Areas Following the Medicare Modernization Act of 2003, North Carolina Rural Health Research and Policy Analysis Center, Findings Brief, August 2011.

A video that explains fixed cost transfers is available at

<https://www.youtube.com/watch?v=Ym75Tkka-xI>



Boots on the Ground Operational Issues

Susan Starling



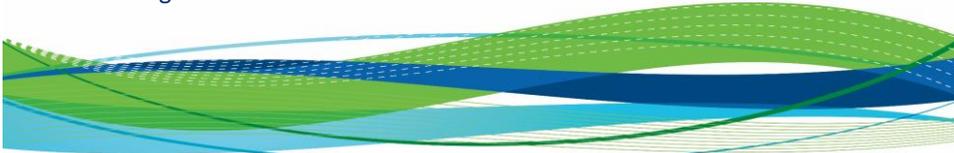
Discharge Planning Process Standard Operating Procedures



Assessing the patient's discharge needs begins at the time of admission.

Appropriate placement is based on the patient's medical needs.

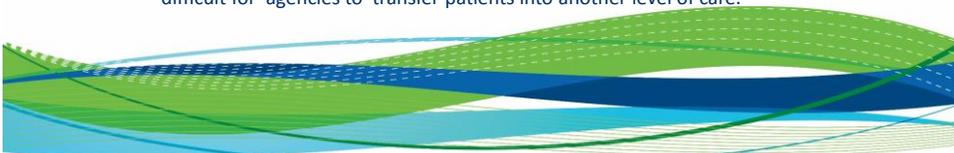
- The patient requiring health care service when returning home is referred to home health services
- The patient requiring long-term health care at time of discharge will be transferred to appropriate level of care in a long-term care facility
- If appropriate health care services are not immediately available for patient at the time of discharge, the patient may be admitted to the swing bed.



Home Health Services Barriers to Obtaining Home Health



- Lack of availability of home health agencies in rural communities
- When follow up care is required- transportation via EMS is not covered by Medicare for the home bound patients (excluding Dialysis).
- Acceptance of a patient is dependent on multiple factors. Listed below are some of the factors considered by agencies.
 - **Traveling-** distance, time, and terrain to patient's residence.
 - **Type of Insurances-** Private home health agencies are selective and patients may be denied due to type of insurance coverage (no Medicaid)
 - **Support at home-** In addition to home health staff there needs to be a "willing and able" provider to continue to provide care to patient (IV's, colostomy changes, dressings etc.) This is usually a family member .
 - **Acuity of Patient's** – Home Health agencies are cautious, once they accept a patient and they find it they are unable to meet the needs of patient, it is difficult for agencies to transfer patients into another level of care.



Long-term Care (LTC) Barriers to Patient Placement

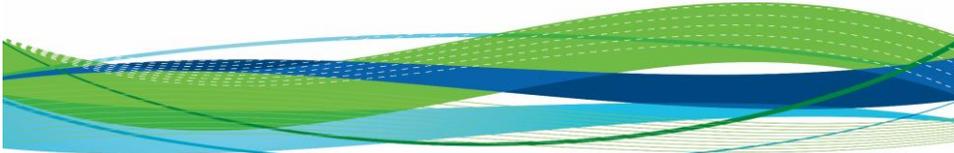


There are challenges to placing a patient to in LTC

- For payment by Medicare, a patient must have a **3-day** qualifying hospital stay (within a 30 day period) prior to admission to the LTC facility. Without this hospital stay, Medicare will not cover the admission.

The type of patient can be a factor in placing patient in LTC. Patients who maybe denied acceptance to LTC include:

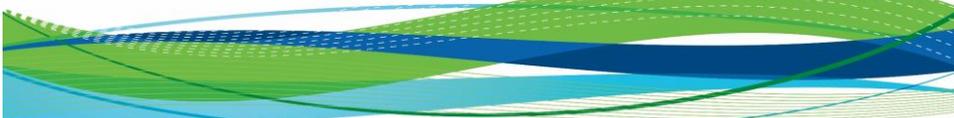
- Patients who are categorized as high acuity
- Patients who are considered high utilizer of resources. These resources can be categorized as financial resources and/or human resources.



LTC Placement Barriers from a Financial Resource Perspective



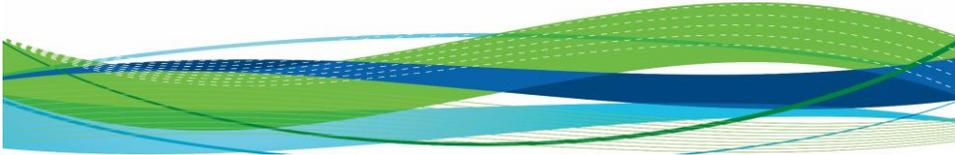
- The patient who requires follow-up health care and is dependent on EMS for transportation to obtain these services. Examples include:
 - Orthopedic follow up
 - Chemotherapy/Radiation
 - Intensive Wound Care
- Homeless
- Uninsured
- Medicare Advantage Plans (Anthem, Humana....)



LTC Placement Barriers from a Human Resources Perspective



- Patients who require significant amount of skilled nursing care or other skilled monitoring
 - Feeding tubes, bed sores, dressing changes, wound vacs, and colostomies
- Patients requiring continued monitoring to ensure safe environment
 - Behavioral issues which includes combative, confused, or disoriented patients
 - Patients who present with safety risks (falls, wandering..)



LTC Placement Barriers from Human Resources & Financial Perspective



- Patients requiring expensive IV antibiotics therapy or other expensive medications
- Morbidly Obese Patients
- Patients requiring respiratory therapy such as high liter flow of oxygen, bipap, or tracheostomies.
- New diabetics



Swing Bed Utilization



- Swing beds are utilized when patients present with the financial and human resource barriers and LTC placement is not available
- Swing beds are utilized when the physician determines that a transfer to LTC or home is detrimental to patient's condition
- Swing beds are utilized when we need to preserve the continuity of care (2-3 days disruption of service when patient is transferred)
- Additional Issues
 - Lack of availability of long-term care beds (holding patient in SWB status until they can be transferred when bed becomes available that is the appropriate level of care.
 - Patient requires short term placement in swing bed
 - Palliative care where death is imminent
 - Patients in tertiary centers who want recover close to home
 - Lack of transportation for families to visit patients that are placed outside of the community
 - Overall stigma of LTC placement



Limited Options in the Rural Community Continuum of Care



Lack of availability of services in the "Continuum of Care" contributes to the utilization of the Swing bed in our rural communities

- Limited Home Health Services
- Limited Long-term care
- Lack of hospice beds in community
- No Specialized Long-term care facilities /Units (Bariatric, Alzheimer's, Respiratory, ...)
- Most L-TACS in urban areas-
- Lack of personal care provider services for home care Limited availability for rehabilitative services such as OT/PT/Speech
- Limited or no access to community agencies such as meals on wheels or other home-delivered meals
- Limited access to assisted living (distance and cost prohibitive)



Utilization of Swing beds
is Multifactorial -



And can not be thought of as just a cost and/or
mileage issue.

Other important factors include:

- Quality of care
- Patient needs
- Access to appropriate care
- Patient outcomes



Rural Attack



- Moving forward the focus needs to be on viable solutions for rural communities. Rural is not a mini-urban area - our needs and issues are different, but they are as important as urban community.
- We should not have to continue to jump through hoops....first the patient has to be confirmed to need a 48 hour stay, but discharged or transfer at 96 hours. And now the focus is on Swing bed status? Can we please just focus on what important

Caring for the Patient!



Q & A

Submit questions using Questions section of your control panel

Speaker Contact Information:

- Kristine Sande ksande@raconline.org
- Brock Slabach bslabach@nrharural.org
- Kristin Reiter reiter@email.unc.edu
- Susan Starling sstarling@mercy.com

Thank you!



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