

Kristine S: Thank you for joining us today. I think we've got a great webinar for you Swing Bed Reimbursement and Critical Access Hospitals. As you probably all know the office of the Inspector General at the US Department of Health and Human Services recently released a report entitled "Medicare could save billions at critical access hospitals if Swing Bed Services were reimbursed using the scale nursing facility perspective payment system rates."

The report looked at Swing Bed usage and payment over a 6 year period. They found that Swing Bed usage had increased significantly in that time. Estimating that 90% of critical access hospitals had alternative facilities within 35 miles, that could provide similar care and that the Medicare program could have saved \$4.1 billion over the 6 years if CAHs were reimbursed at the skilled nursing facilities PPS rates instead of the current Swing Bed reimbursement structure.

Since the release of that report there have been many thoughts, opinions, perspectives offered on the study's methodology and what such a change would really mean for rural hospitals and patients. We've got some great speakers today who will weigh in on those issues. I'd especially like to thank the NRHA for helping us out in making their webinar platform available today so we could let more people join us since we have such overwhelming interest in this webinar.

Hopefully you are all seeing my slides. We do hope that we will have time to take your questions at the end of the webinar. If you do have questions for the presenters, we ask that you please submit them towards the end of the webinar, using the questions section of the, go to webinar control panel.

We've also provided a PDF copy of the presentation on the RAC website. That's accessible through the URL that you on your screen or you could go to [www.raconline.org/webinars](http://www.raconline.org/webinars) and click in today's presentation and then you'll see where you can download those slides.

We'll be recording the webinar today and we'll make that recording available on that same page on the RAC website. I'd like to introduce our speakers. Our first speaker will be Brock Slabach who currently serves as the senior vice president of Member Services for National Rural Health Association or NRHA which is a membership organization with over 21,000 members nationwide.

Mr. Slabach has over 25 years of experience in the administration of rural hospitals, from 1987-2007 he was the administrator of the Field Memorial Community Hospital in Centerville Mississippi. He earned his Bachelor of Science degree from Oklahoma Baptist University and his master of public health and health administration from the University of Oklahoma.

Our next speaker is Doctor Kristin Reiter, an associate professor in the department of health policy and management at the University of North Carolina at Chapel Hill and a research fellow at the Caesar Bishop Center for Health Services Research. She received her PhD in health services organization and policy with an emphasis in corporate finance in 2004 from the University of Michigan.

She also holds a master's degree in applied economics from the University of Michigan. Prior to her PhD she worked in public accounting at Deloitte & Touche LLP in Chicago Illinois.

Her primary research interest is understanding issues important to the financial and operational performance of rural hospitals. She is an investigator with the North Carolina rural health research center and a contractor with the North Carolina office of rural health and community care.

She also studies the financial implications of important policy or practice changes such as minimum nurse staffing requirements, patient centers, medical homes and meaningful use in quality improvement.

Finally, we will be hearing from Susan Starling, the CEO and president of Marcum and Wallace Memorial Hospital in Irvine Kentucky. For more than 20 years Ms. Starling has been working in rural health, first as a nurse and for the past 12 years as a healthcare executive. Susan's commitment to rural health is fueled by her steadfast belief that rural Americans particularly rural Kentuckians deserve access to quality healthcare.

Susan who earned her master's degree in community rural health administration at Eastern Kentucky University has worked diligently to transform the quality and delivery of healthcare in upper Eastern Kentucky. Since 1991 she has served in senior management and is currently the CEO and president at Marcum and Wallace memorial hospital, a critical access hospital in Irvine Kentucky and a member of mercy health.

Susan presently serves on the board for the National Health Association in Cherry Dale Hospital Constituency Group. She serves on the Kentucky Rural Health Association board, serves on the Technical Assistance Services Center Advisory board for the National Rural Health Resource Center. She chairs the rural health issues group for the Federal Office of Rural Health Policy and is also involved in many other state and local organizations.

She's been recognized for her leadership in rural health with her most recent recognitions, the Shirley Monroe leadership award from the American Hospital Association. Also Beckers 50 rural hospitals CEOs to know, Becker is a 130

women hospital and health system leaders to know, the impact award winner by Blue Grass Alliance for Women and the Dan Martin award by the Kentucky Rural Health Association. With that I'll turn it over to Brock for his presentation, Brock.

Brock: Thank you Kristine and thank you for the opportunity to participate in this important discussion today. The issue, Swing Bed reimbursement has been looked at periodically over the past decade actually by MedPAC and others, including studies by the rural health research centers. Just a couple of weeks ago, the office of inspector general released their report on this topic.

Before I provide a little historical background on Swing Bed, I'd like to take a moment to explain a little bit about the office of the inspector general. Even though they are at the Department of Health and Human Services, they are an independent entity which is deciding on what they will study and what they will report on. It sometimes resolves in recommendations which are non-binding and certainly have, may have no impact down the road.

Given all of the attention that this report is bound to generate around the subject, I appreciate Kristine and the Rural Assistance Center in helping to organize this webinar today and to provide a forum for stakeholders to better understand what we know currently about the Swing Bed services from historical, methodological, and a practical perspective.

I will address some of the historic issues, Kristin will handle some of the methodological issues and then we'll close with Susan Starling on the practical perspective. I hope it provides an opportunity and a common understanding for everyone to talk objectively about Swing Bed services and reimbursement, which is an important discussion to have regardless but particularly, in light of this OIG report. We really want to make sure that everybody is up to speed and they understand the details about what we are talking about.

Let's start with a little background. The first bullet is the critical access hospitals were authorized by the balance budget act of 1997. The OIG, the Office of Inspector General report offers the statutory background on the creation of critical access hospitals and even goes into some of the reasoning behind the designation.

The CAH program was intended to improve the financial viability of small rural hospitals that would be negatively affected by Medicare's inpatient perspective payment system. Lastly by reimbursing CAH as per Medicare services on the basis of cost, the law aimed to cease closure of these hospitals and more importantly maintain access to care in isolated areas.

What I would like to offer in addition is further context on the why Congress created Swing Beds in the first place. Swing Beds were part of a number of changes that Congress enacted following a period of closures of small rural hospitals that extended from the 1980s through the 1990s.

The creation of the Swing Bed was done in recognition of the need for staffing and service delivery in small low volume hospitals. I quote, 'to maximize flexibility of rural providers to deliver the care needed by its population on any particular day, Swing Beds are acute beds that can be used for skilled nursing care and this allows for more efficient use of limited resources, staff beds in other words, to provide a variety of services across a continuum.

The ability to and I use the term in quotation, 'swing' a patient is basically that you transition a patient from care between acute and skilled nursing services. This creates efficiencies for small rural hospitals that took into account then their small size to be able to move patients effectively using resources already available in the community.

MedPAC, the Medicare Payment Advisory Commission testimony back in march of 2005 explained that a Swing Bed day or any type of patient day results in spreading the hospital's fixed costs over more inpatient days, hence the expenses allocated to Medicare acute days will be reduced when Medicare Swing Bed days are increased.

In just a moment we are going to hear from Christine Rider at the North Carolina Rural Research Center on how that is the case through an explanation of cost based accounting.

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

The entire report that the Office of Inspector General issued is available online. So I won't go into the detail of how the review was conducted. But in summary, the report makes one particular recommendation and that is the CMS seek legislation to adjust CAA swing bed reimbursement rates to the lower sniff PPS rates using the resource utilization group process paid for similar services at alternative facilities.

As a proxy, that access would not be adversely affected by such payment policy reports notes that of 100 CAHs randomly sampled 90 had alternative facilities within 35 miles with alternative skilled nursing care services available.

In considering if equivalent post-acute services are provided at free standing sniffs and hospital swing beds; the office of the inspector general determined that they are the same. Citing the language in federal code in defined similar sniff care to be available if sufficient bed capacity was available. Report also cited recent research stating patient characteristics are comparable regardless of post-acute discharge destination.

However, because Resource Utilization Group or RUG coding is not done for swing bed patients, it's not possible to compare the level of care provided to swing bed patients with care provided to sniff patients or to confirm that equivalent care is truly available in free standing sniff beds.

Clearly there would still be a significant number of alternative sites where beneficiary currently served by a CAH swing bed could get skilled care services but even then Medicare would incur cost of transfer from hospital to the sniff that would not be incurred with swing bed utilization.

The report did note in appendix A footnote 22 that's the OIG report that the comparison of cost does not include the additional cost for transporting beneficiaries to an alternative facility and therefore the estimated potential savings may in fact be over stated. The report estimated that Medicare could have saved 4.1 billion that's with a B over a 6 year period if payments for swing beds services at CAHs were made using the sniff perspective payment system rates.

So while we see the way the report identified alternative sites for skilled nursing care as a proxy for access and it obviously has short comings. There are even more shortcomings with the methodology used to estimate savings. One significant issue this slide points out is a potential impact on access. What if adjusting CAH swing bed reimbursement rates to the lower sniff PPS rates were to happen? How might we estimate how CAHs would discontinue swing bed services as a result of losing cost base reimbursement?

Well for a historical proxy one might look at how many CAHs close there long term care nursing units due to the cost reporting ramifications and the financial impact of having nursing facility beds. What we can see from the information on the slide is that if a CAH discontinues Swing Bed services due to the recommended changes in policy, payment policy suggested by the OIG that would mean that for almost 20% of counties across the nation there would be no post-acute skilled care available.

The report estimated that Medicare could have saved 4.1 billion dollars over a 6 year period of payment for Swing Bed services that cost were made using sniff BPS rates. So while we see that the way the reports defined the available bed as

a proxy for access to equivalent care, a level of care has shortcomings, there are even more shortcomings with the methodology used to estimate savings.

Cost report data shows that sniff utilization a good proxy for both link of stay in additional cost to Medicare is substantially higher in free standing sniffs than in hospital based sniffs or swing beds. So this chart illustrates how a comparison of the only per diem and rates and not also free standing sniffs link the stay could easily lead to an over estimation of saving to the Medicare programs.

Once again, little is known about the acuity of CAH to swing bed patients relative to a sniff patient. But if the acuity of a patient in either a swing bed or a sniff exceeds the level of skilled care provided that patient in the free standing sniff will result in an additional ambulance transfer, an emergency department visit, and possibly even hospital readmission that the swing bed patient would not incur in order to receive the necessary level of care.

In fact there was a November 2013 OIG report stating that in the fiscal year of 2011 nursing homes, including skilled nursing, transferred one quarter of their Medicare residents to hospitals for in patient readmissions. Medicare spent 14.3 billion dollars on these hospitalizations. It's also been pointed out the cost report ramifications of changing if the swing bed was converted to a PPS environment.

The cost reports would look far different from what they do today with a significant increase in CAH acute care cost. Therefore, Medicare reimbursement for CAH acute care services would increase significantly which would eat into the 4.1 billion dollars in savings the OIG quotes in appendix F of the report.

It certainly wouldn't wipe out all of the 4.1 billion dollars but it would be surprising if it released at least 3 billion dollars of the OIGs estimated savings. So this is another fallacy I think that would be introduced in terms of the methodology of the OIG report.

In a pleasant surprise CMS administrator Marilyn Tavenner in responding to the reports release suggested that indeed these savings are also inflated. With additional costs of all of these, it may be difficult to quantify. The cost of these avoidable transfers, emergency department visits and readmissions should not be excluded as any objective analysis of potential Medicare savings for simplification purposes.

Now at this time I'm pleased to welcome Kristin Reiter and she is going to present to us now regarding the methodological issues regarding Swing Bed reimbursement, Kristin. I think you might be on mute Kristin.

Kristin: Thank you very much. Yes I was I appreciate that. Small technical snap, thanks so much for the opportunity to be here. As Brock said I'm here to talk about one aspect of the methodology used in the OIG report and that is the cost accounting used to compute the per diem rate that was used to calculate the savings. I'm going to do that through a study that we did in 2013 looking at the cost of Medicare of swing bed days provided in critical access hospitals.

I would like to start with a brief background, some of this will be a little repeat to what Brock mentioned. In 2006 the Medicare team and advisory commission published a report to the Congress describing the effect on Medicare reimbursement of curving swing bed days back into the critical access hospital reimbursement formula after a period during which they had been carved out and paved separately.

Essentially, what it looks like OIG is suggesting is again curving some bed days out of the formula. As MedPAC notes in the first passage highlighted in blue at the top of the slide CMS currently divides hospitals total in patient routine cost by the sum of the acute and post-acute days including swing bed days to arrive at an estimated retain cost per day or per diem rate.

It is this per diem rate that is used to determine interim payments for acute and swing bed days in critical access hospitals. In the second passage you see highlighted in blue MedPAC also notes that compared with the reimbursement method where swing bed days are carved out and paid separately the new formula results in a reduction in payments for acute days because some of the fixed costs of providing routine in patient care are transferred from acute care days to swing bed or post-acute days.

Finally in the third passage highlighted in blue MedPAC notes that the result is that the true cost to Medicare per swing bed day is actually not equal to the full per diem payment but rather to something less. In other words, what hospitals might win on swing bed days they are losing on acute days and the net result is that rather than the full \$4,000 per diem in 2006 each additional swing bed day was estimated to cost Medicare only about \$400 to \$500 once the fixed cost transfers are accounted for.

My job today is to better explain what all of this means. This part of the webinar is very technical and as you'll see in a moment I'm going to use a very silly example to motivate it. But first let's take a look at Medicare's current formula for determining reimbursement for routine in patient care in critical access hospitals.

The formula shown here on the left you can see the calculation of the hospital per diem rate for routine inpatient care cost. The cost of nursing facility type

swing bed days is carved out of total cost because it's paid by Medicare. There are many in patient routine cost is then divided equally among acute days, filled swing bed days, and observation days.

On the right you can see that the resulting per diem cost is multiplied by the number of acute and swing bed days covered by Medicare to arrive at total Medicare interim reimbursement. Next I'll talk through my silly example to give you an idea of how the transfer of fixed cost works. I apologize to those of you who are already intimately familiar with this issue, not might be a good time to check your email.

So let's say for a moment the 2 families; a family of 2 and a family of 4 decide to rent a fishing boat for a day and decide to divide the cost equally per person. The total cost rent the boat is \$840 regardless of the number of passengers. In other words the cost of the boat is the fixed cost, or the cost that does not vary with volume. With 6 people the cost per passenger is \$840 divided by 6 or \$140 per person. At a rate of \$140 per person the cost of family one is 140 times 2 or \$280. The cost of family two is 140 times 4 or \$560. Now let's assume one member of family two decides to stay home, this is the person highlighted in grey that's up to the right of your screen.

If you take the fourth member of family two out of the equation you might think that the savings to family two would be \$140 or the cost per person. But if you look if that were the case the 2 families together would only be paying \$700 in total; the \$420 plus \$280. The fixed cost of the boat is still \$840 and needs to be covered. As you can see here with only 5 passengers the new cost per passenger is 840 divided by 5 or \$168. So the new cost of family one is now 168 times 2 or \$336. The new cost for family two is now \$168 times 3 or \$504. So what has happened? You can see the removal of a passenger has resulted in the transferred fixed cost from the person staying at home back to the passengers that remain in the boat.

The cost of family 1 goes up, family 2 says because they are now paying for one less person however the savings that is only \$56 but not the original rate of \$140. So why did this happen? The fixed cost of the boat rental is now spread over fewer people. Now instead of a boat rental assume the \$840 in fixed cost is the fixed cost of routine in patient care in a hospital.

These are the costs that keep the hospital emergency department staff, maintain the building, pay for core clinical and administrative salaries, it keeps the lights on. These are the costs that don't change if patient volume increases or decreases. In this new example family one is non Medicare days, family 2 is Medicare, the 3 people from family two that remain in the boat are the acute days. The person that stays home represents because the cost of each acute care

days goes up as the less the increase in the cost of acute days less the new, this brings me back to our study.

The aim of our study was to estimate the cost of Medicare for critical access hospital swing bed day after accounting for the transfer of fixed cost from swing bed days back to acute. In order to estimate this cost we recalculated Medicare reimbursement for routine inpatient care for each critical access hospital assuming that Medicare covered swing bed days was equal to zero.

In other words we assume Medicare swing bed days were carved out of the reimbursement formula. We first recalculated the per diem cost for routine inpatient care. We reduce total inpatient cost in the numerator by an estimate of a variable cost associated with each Medicare swing bed day.

So for example the cost of any supplies, laundry, meals and other costs that are created by the fact that someone is in a swing bed. We reduce total inpatient days in the denominator by taking out the Medicare covered swing bed days. Finally we multiplied the new per diem cost by the number of Medicare covered days after taking out the Medicare swing bed days.

To get the implied Medicare expenditure on a swing bed day, we took the original Medicare reimbursement for routine inpatient care including swing bed days from the cost reports and subtracted our recalculated reimbursement amount assuming swing bed days were carved out. This produced an estimate of Medicare savings from the removal of swing bed days from the formula.

We then divided this estimate of savings by the total number of Medicare swing bed days in 2009 to arrive at the implied Medicare expenditure on a marginal swing bed day. This essentially is an updated estimate of what MedPAC reported in 2006 to be about \$400 to \$500.

So what do we find? In 2009 we estimated that the marginal or variable cost of a swing bed day for example; supplies, laundry and meals was about \$262. Accounting for fixed cost transfers back to acute care, the implied Medicare expenditure on the marginal swing bed day was about \$581. This compares to an average routine inpatient per diem cost when swing days are included in the formula of \$1,302.

So based on our estimates if swing bed days were removed from the formula, the cost of each acute in patient day would increase by about \$721 on average. Here we compare estimated Medicare savings from a change in payment methodology something very close to the method OIG used and data from our study.

Using the per diem method of OIG the savings for Medicare per swing day from reimbursing swing days at the PPS rate would be the difference between the average per diem cost and the average PPS rates. This results in savings of about \$1,038 per day in 2009. Accounting for fixed cost transfers however we estimate the savings to Medicare at only about \$317 per swing bed day.

Based on their estimate in 2009 the OIG estimates of Medicare savings could be as much as 3 times too high. Of course it's important to note that these are only estimates and the actual savings to Medicare would depend on implementation of the new payment methodology and the amount of variation across hospitals and the implied Medicare expenditure per swing bed day. We did find some variation and these estimates presented here are averages.

Based on our study we believe it's important to differentiate between the true marginal or variable cost of a swing bed day. The average reimbursement rates for inpatient days which is the current per diem and the marginal reimbursement rate which is the reimbursement rate after accounting for changes in the per diem resulting from addition or exclusion of swing bed days from the per diem calculation.

It's also important to recognize that any changes in payment policy would affect individual hospitals differently depending on the relative mix of swing versus acute days in the hospital and Medicare share of swing and acute days. Thank you for your attention. Here I have provided some citations to some of the studies done by the North Carolina Rural Health Research Program and a link to a YouTube video that explains fixed cost transfers. I think this was also provided in your invitation. I would also like to let you know that based on our work later today we will be releasing a critique of the methods of OIG reports.

You can get it by going to our webpage, search for North Carolina Rural Health Research Program and it's also linked to our Twitter account @NCRural. Now I would like to turn it back over to Kristine, thank you.

Kristine: Thank you so much that was really interesting. Now I just want to remind everyone that you will have a chance to enter your questions for Brock and Kristin as well as for Susan at the end of the presentations. So at this point I will turn it over to Susan.

Susan: Okay. Thank you good afternoon. This is more of operational issue presentation for us it's shifting the focus and I am CEO at Marcum & Wallace Hospital we are a critical access hospital located in central Kentucky we are a part of Mercy Health based out of Ohio.

Our presentation today is based on my experience with the swing bed program. My goal is to share some of the issues that my hospital faced. My focus is on the operations at my operation. As you know each critical access hospital is different so we may share some of the issues as other critical access hospitals but there are also maybe some differences.

Like why is each long term care and home health agency that we will be talking about may be different and what I describe and what happens in our community may be different and reflect differently from what is happening with other long term care facilities and home health agencies.

My goal is to demonstrate why the swing bed program is critical to our community and how this program is a necessary component in the continuum of care. As we look at the swing bed issues the challenges that we face reflect by the cost of care may be higher in the critical access hospital and why the critical access hospital is growing.

Nothing in my presentation reflects on the relationship that we have with the other providers in the long term care and home health as we all work together to make sure that patient has access to the appropriate level of care and it is definitely a team effort.

So let's touch first on the discharge planning process. Not every patient that is admitted to a hospital is discharged in the swing bed program. But it is a necessary program for our rural community. We faced many different barriers when trying to plan for the patient's discharge; and many times the swing bed program is our only option as we ensure that the patient gets the appropriate level of care.

Discharge assessments begin at the time of patient's admission. Our nurses and in care managers work with the patients and the families and physicians and once the patient's needs are identified we start the process working with other agencies to ensure appropriate care is available at the time of discharge. As a critical access hospital we have a 96 hour target to either transfer or discharge a patient. So we don't have much time to spare.

Unfortunately we have limitations and at the time of discharge the swing bed program may be our only appropriate option for a patient that's going to be discharged. Now I would love to say that everything works well with the discharge planning process and that the process for care after hospitalization is very streamlined, unfortunately it does not necessarily work that way.

Each patient and each agency have specific needs and we need to work through their system, what patients are appropriate for them and what skill level they

can handle. So what options do we have? One is home health but there are barriers to this and the acceptance of the patient is dependent on multiple factors such as travelling, distance time and train to the patient's residence. CEOs in frontier areas have communicated that distance is a huge challenge for them as they try to get home health services to accept their patients.

Our issue in Kentucky is terrain; mountains and curvy roads, time of travel impacts their home health financial status. The insurance is an issue, private home health agencies are selective and patients may be denied due to the type of insurance coverage they have. Most home health that we have been working with do not accept the Medicaid patient.

Additionally home health staff can't meet all of their patient needs, home health has limited visits and their focused on education. The patient must have support at home, there must be a willing and able provider in the home to continue the care that the home health is providing.

Then there is security of the patient. The patients that we discharge have continued health care needs and have multiple problems, they are sick, the agency must feel comfortable what they can provide the level of care that the patient demands. Currently home health services is available in our community but it is very limited.

Just in the past month a long standing home health agency discharged most of our Medicare patients that were in our county. We had over 80 of our patients who were discharged in just one day. I'm also afraid that this is not a onetime event and our patients will continue to have limited access to home health services in our rural communities.

Another option for our patients upon discharge is skilled nursing care. In my slides I use long term care for skilled nursing care we are considering them as the same for us. We do not have an intermediate care facility. Again there are barriers to the long term care option before a Medicare patient can be admitted to the swing bed or long term care a patient must have a 3 day qualifying hospital stay.

At times it's difficult to admit a patient in for a 3 day hospital stay as they must meet the criteria for medical necessity. But once this is accomplished, challenges remain in getting long term facilities to accept patients who are classified as high acuity. High acuity patients can be high utilizers of resources. The resources are either financial and or human resources.

This is an issue some of the skilled facilities are reimbursed in a different manner. The patients that are considered as high utilizers of resources are the

patients that are challenged for us to get and transfer to a long term care, hence they are the patients who are in our Swing Bed program.

From a financial perspective; listed below are the examples of the challenges we face if a patient requires transportation via EMS for follow up care this is an issue since the long term care has to cover the cost for this service. In the homeless or the uninsured long term care agencies do not readily accept patients that can't pay. Fortunately, at our hospital we continue to care for the patients regardless of their ability to pay. In the past we have had several patients who could not pay. One patient who was homeless was in our Swing Bed program for over 100 days. Our community does not have a homeless shelter and the patient did not have Medicare. There were no other options but a Swing Bed program for this patient.

During the time he was in our facility we applied for Medicare and once he was approved for Medicare he was then accepted into a long term care facility. Human resource barriers relate to work force issues. Staffing is limited at the long term care and patient's conditions who may consume the staff time are not the facilities' first choice. The RN to patient ratio in the long term care is higher than in our swing bed unit and many times they are not able to handle the patients who require a significant amount of skilled care.

Patients whose conditions demand attention to maintain safe patient environment or needed a significant amount of one on one are also a challenge to place. These are the patients who utilize our Swing Bed programs. Other barriers for placements of patients include once whose conditions require specialized care.

The obese or bariatric patients and the respiratory patients require specialized care and specialized equipment. Bariatric or obese patients require the larger beds, sheets, mattresses, wheel chairs, special lifts, they need more staff to appropriately move the patients in an effort to avoid staff injuries and avoid worker's comp issues, from a safety perspective in the older long term care facilities, an obese patient in a bariatric bed can be a fire hazard as you can't get the larger bed through the door frames. The patient respiratory needs presents limitations, most long term care facilities do not have the equipment or the staff to provide the 24/7 respiratory care. These are the reasons why the Swing Bed program is so necessary in our rural community.

This slide covers why the Swing Beds are utilized in our hospitals and why the Swing Bed program is so important. There has to be options for patients upon discharge in rural communities. The swing bed is really a good solution, utilizing the Swing Bed program can reduce the patient plan to stay.

The Swing Bed staff is already familiar with the patient and their needs and there is no learning curve involved when the care transitions. When transferred in outside agency the continuity care is interrupted and a learning curve for the new provider can prolong the patient's length of stay in the long term care facility.

The patients who are dying but don't require acute care hospitalization, do they need to be transferred into an unfamiliar environment during their last days? Our community and rural communities face the challenges that are not an issue in urban area. Urban hospitals have access to numerous options in the continuum care for patients upon discharge.

As you can see, our options are limited. My father in law was recently discharged from a hospital in the Washington suburb area. The social worker provided me a list with over 25 facilities to choose from for his long term placement. All facilities had access to public transportation.

But unlike in our community we have an option of 1 or 2 facilities that are close. Since we do not have public transportation, no buses or taxis in our community, patients want to be close to home. The lack of availability of service in our community dictates that our Swing Bed unit needs to be able to care for patients with special needs. Our mission is to meet the needs of the patients, regardless of the issues and their ability to pay. Acute staffing needs are not an issue. We have the staff and we have the resources to be there when the patients and the families need us most.

That was an overview of some of the challenges that we face hence why the Swing Bed program is so important to our rural communities. We need this program to help address the healthcare needs of our community that we serve. It's not just about the cost and it's not just about the knowledge, it's about quality access and patient outcomes. At the end of the day the Swing Bed program is a viable solution for all our rural communities, can we stop the attack on rural?

With all the issues that we face at the critical access hospitals and all the hoops that we have to jump through the inpatient must stay at least 48 hours but no longer than 96 hours and now we have to defend our Swing Bed program. Can we please just focus on what's important and let's do the right thing? Let's focus on the patient and that's what we do in rural and that's what makes rural special, Brock?

Brock: Thank you Suzie. That was a tremendous overview of the importance of the community based services that remain vital in our rural communities. I'm going

to turn it over back to you Kristine and we'll begin the Q and A and any more comments.

Kristine: Alright, thanks Brock and thanks to all of our presenters today. That was really interesting and valuable information. It looks like I'm having a little trouble here with Q and A Brock, are you seeing any questions?

Brock: Yeah, there is a couple that I'm noting. Suzie there was one directed to you, how many beds and how much annual revenue and that's in gross for your hospital there in Kentucky?

Susan: I have to get back to you on that one I don't have those numbers. We are a 25 beds critical access hospital and I don't have my gross revenue in here.

Brock: Thank you. Do you see the next question Kristine?

Kristine: There are some questions about the slides and those are available on the RAC website and we will also make sure they get sent out to everyone along with the recording. Here is a question for you Susan. Do you have push backs from nurses who do not want to take care of a nursing home patient?

Susan: No, we don't have any push back at all. They are all patients we are caring for, we don't look at them as they are different between nursing home patients or in patients, et cetera, they are just our patients.

Kristine: Can PA or an NP admit to a Swing Bed?

Susan: I think each stay is regularly different but we do have nurse practitioners who work with our hospitalists for admissions to the Swing Bed unit.

Kristine: Another one Susan, are you saying that you admit patients to Swing Bed that are dying, and how do you qualify them?

Susan: Basically they've been in our inpatient area and we go with guidelines, when there is certain guidelines we follow, then you are allowed a certain amount of time for the patient to be observed. Then there is depending on what are the things that you are doing for them. We follow an InterQual criteria.

We have not had any problems but yes we do keep a patient whose death is imminent in our Swing Bed area.

Kristine: Brock it looks like there are several questions related to who should they contact if they want to voice their concerns over this issue? Another one, how do we feel regarding the legislation and whether or not we can win this one?

Brock: Thank you Kristine, that's a very important question, I was going to make that comment in closing but first I would suggest that everyone contact their, representatives and their senators and they express their dismay over this report and seek their commitment to not make any effort to advance this proposal from the OIG into legislation.

That would be the first and foremost thing that you can do and talk about the things that we visited on here on this webinar and Suzie did a great job in summarizing what it means for patients. If you were to incorporate those kinds of venues into your stories to your legislators there would be I think a very, very important issue.

Also you can follow NRHA's website. We post information frequently on things that are vital to you all as rural providers and CAHs running Swing Beds. You can check out our website, also we have a blog. You can connect to our blog through the top line of our website. Then through our member only site, which is NRHA connect, I will typically blog and provide resources to members in that format as well.

Those are some of the ways in which we can continue to make communication known for you to be able to act when necessary, any other questions Kristine?

Kristine: Yes, it helps that I'm not on mute. Can you explain the main differences between the CAHs Swing Bed program or Swing Bed and non CAHs Swing Bed?

Brock: I'll go ahead and fill that, a Swing Bed and Kristin you might want to jump in on anything that I've gotten incorrect. A Swing Bed is part of the inpatient complimentary services within a critical access hospital. Actually PPS hospitals, less than 50 beds are eligible for cost based reimbursement as well in a Swing Bed format.

It's not just exclusive to critical access hospitals but these are programs and services that allow for the utilization and the efficient utilization of resources that can be made available in a rural community, that otherwise would not be present.

I think that's what the legislation was originally intended for 1997, when this program was created, Kristin any further insights on that?

Kristin: No, I think that covers it.

Kristine: Follow up on your statements about following up with legislators Brock, which house or senate committees would be most likely to forge any such legislation?

Brock: If it was in the Senate it would, if there was any it would go to Medicare where the legislation which would generate typically in the Senate finance committee. On the house side it could probably come through in a number of different committees in that particular venue has ways and means, energy and commerce. I think the critical thing is to make sure that your own individual senators and representatives are well aware of your view on this particular topic to make sure that this doesn't see the vote of day.

We were very successful I will say historically, just to follow up on that, when the OIG releases report on the necessary provider provisions and recommended that we begin to end the necessary provider program for critical access hospitals.

The blow back to Congress was really high and congressmen were denouncing that report and publicly stating that they weren't going to be participating in any legislation to address that issue. I think we can generate the same kind of interest after this and I think the first case that was very effective and I think we can be very effective in this case as well.

Kristine: Well great, thank you. We have comment here from Kara, she says they recently had an issue due to flu and pneumonia where local nursing homes were full and patients would have to go over 50 miles from home if they didn't have the Swing Bed program in the critical access hospital there. I think that's a nice example of why it's so important. Brock will NRHA have some talking points for people who are interested?

Brock: Yes, we have those available on a blog that I wrote a couple of a week or 2 ago, that's available at our website if you go to through NHRA connect then you can get access to that, the talking points are found in sort of the resources that are available and resources available to you through that venue.

Kristine: A comment here from Tim also, regarding the PPS hospitals in the Swing Bed program there, it says Brock, PPS hospitals do not get any cost based reimbursement for Swing Beds regardless of bed size, we are paid under RUGs just like skilled nursing facilities, thank you for the clarification.

Brock: Yeah, that's a historic, like I see it's something that crept into my faulty memory there and that's no longer true, so that's correct.

Kristine: We do have a question on Medicaid and whether, if a patient has Medicaid are they eligible to stay in the CAH for Swing Bed. The question says, "My understanding is they need to go the nearest nursing facility for sniff stay.

Our nearest nursing facility stated that with Medicaid being the only payer and not having long term care Medicaid he was not eligible for the facility and the

patient didn't have SSI either." Just wondering about the eligibility, do any of you know?

Susan: Our patients, Medicaid pays for patients in our Swing Bed, in our state we are cost based reimbursed for Medicaid except now we've transitioned to a Medicaid managed care company. We are seeing that the Medicaid and manage care companies are denying patients to Swing Bed status.

Kristine: Okay. A couple of other comments here, one is that, "Most of our patients in Swing Bed are post Op orthopedic patients, they do not want to rehab in another city that's an hour or more away from home, that's why their Swing Bed program is so important."

Another commenter says that all of our skilled nursing facilities refuse to take any patients requiring IVs and other more intense services. Looks like some of the Medicaid varies by state, other people are commenting. Here is another question, "I've been asked in regard to distance needed between a Swing Bed hospital, not a CAH and a long term care facility, is this regulated?" anybody want to take that one?

Kristin: This is Kristin, I don't know of any distance requirements.

Brock: There is none that I know of either and if there were any it would be state dictated, if particularly they have certificate of need requirements, which are waning out in terms to the number of those. I would agree.

Kristine: I think we have covered all the questions that have been asked so far, here is one more that just came in, please clarify 3 day inpatient stay before Medicare sniff coverage, does the patient need to be in an acute bed for 3 days before both swing and sniff?

Susan: It's my understanding yes but the 3 day qualifying a hospital stay as an inpatient but if a patient within a 30 day period for Medicare. For a patient who's in a hospital stay and went home and then they found out that that was not an option for them and they needed to one time into a Swing Bed, as long it's within a 30 day period from their 3 day qualifying hospital stay, then we would be able to take the patient into it and Medicare would cover it.

Kristin: Those are the federal regulations.

Kristine: Thank you, I think since we are awfully close to the one hour mark that we'll wrap up. Thanks again to our presenters today and for everyone who participated. We really appreciate you being with us today. This is an important issue, we appreciate your interest. Once gain the slides views in today's' webinar

are currently available at [www.raconline.org/webinars](http://www.raconline.org/webinars) and then look for today's webinar, the slides are available on that page.

In addition, a recording and a transcript of today's webinar will be made available on that same page in the next few days, that will give you an opportunity to either listen again or share this presentation with your colleagues. Thank you again and have a great day.

Brock: Thank you Kristine.