



IMPACT OF SWING BEDS

Introduction

A [hospital] swing bed does not swing physically. Rather, it swings in the way hospital accountants and medical staff treat the patient occupying it. In a swing-bed program, a patient being treated for an acute condition could remain in the hospital for follow-up long-term care rather than be discharged to a nursing home. She or he would usually stay in the same bed, but the kind of care would be different, and the accountants would bill for it differently.¹

The swing bed program is now thirty-five years old. It is as much a subject of interest today as it was in 1980 when the legislation was enacted. Since 1980, a number of changes have been made to the program in order to better serve rural communities and their senior citizens. We recognize that each rural region is unique, each with different resources, demographics and geographic considerations, which impact swing bed utilization. However, we have approached this topic with a broad rural perspective. In March of 2015, the Office of the Inspector General (OIG) issued a report analyzing the swing bed program. In summary, the OIG concluded that Medicare could save a significant amount of money if it implemented a site-neutral policy between freestanding Skilled Nursing Facility (SNF) reimbursement rates and Swing Beds.² Following the publication of the OIG report, the Sheps Center for Rural Health at the University of North Carolina concluded that the OIG's methodology was flawed, therefore the OIG's recommendations were based on invalid conclusions.

¹ Sharon Begley, To Improve Health and Healthcare, Volume VI Anthology, "The Swing-Bed Program", (San Francisco, CA: Jossey-Bass, 2003), Chapter 11.

² Office of Inspector General, "Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates, 2015. Washington, District of Columbia: <http://oig.hhs.gov>, 2015.

Historical Perspective

The Swing Bed program is not new. It originated in the early 1960's when beds in nursing homes could be used interchangeably between intermediate or skilled nursing care for patients. Today, the term "swing bed" refers to acute care hospital beds that can be used interchangeably for the skilled or intermediate care patient.

In the early 1970's, a combination of a decrease in Medicare certified skilled nursing beds and more stringent Medicaid standards significantly reduced the availability of skilled nursing care, especially in rural areas. In 1973, the Health Care Financing Administration (HCFA), then part of the Social Security Administration, funded the Utah Cost Improvement Project (UCIP) in response to the need for SNF beds and to make better use of under-occupied rural hospitals. The UCIP involved 25 hospitals and was funded as a three-year demonstration project to assess the viability of providing long-term care in acute care hospital beds, without the requirement that participating rural hospitals meet all regulations normally required of nursing homes.

In 1976 and 1977, HCFA funded three additional swing bed demonstration projects in Texas, South Dakota/Western Iowa, and Central Iowa involving a total of 82 hospitals. These projects, as well as UCIP were all extended, and the majority of the demonstration hospitals continued to provide swing bed care after the completion of the study.

The swing bed approach proved popular in rural hospitals and received both public and private sector support. In addition, HCFA's evaluations of the four demonstration projects found the approach to be cost effective. As a result of these findings, Congress passed legislation for a national swing-bed program in small rural hospitals in the Omnibus Reconciliation Act of 1980.

Federal regulations for the program were published on July 20, 1982 and amended on September 1, 1983.

Swing bed legislation was Congress' attempt to address two significant issues with one piece of legislation: The first issue was the shortage of long-term care beds available in rural areas. This shortage resulted in both patients being discharged home prematurely when intermediate care was still needed, and patients having extensive acute care stays in rural hospitals due to lack of placement opportunities. These issues preceded the Medicare DRG Payment plan of 1983. The second issue was the decline in inpatient census in rural areas. It was feared that unless some patient activity was restored to small rural hospitals, more closures would be forthcoming, placing rural communities in danger of having no or limited access to healthcare services or traditional hospital services. By 1986 close to half of those hospitals authorized to provide swing bed services were certified by Medicare.

Prior to the 1980 decision to allow small rural hospitals to provide swing bed services, many small rural hospitals were unable to provide such services to their communities. Medicare and Medicaid required that skilled nursing and intermediate care facilities be provided in a physically removed, "distinct part" facility used exclusively for long-term care. In many small communities with underfunded hospitals, the opportunity for "distinct part" long-term care facilities was simply not possible.

The result of the above mandates put rural patients in jeopardy and placed additional hardships on rural hospitals. The new swing bed legislation gave hope to patients and their families that they could receive the appropriate care without leaving town or going home prematurely to unsafe conditions. Further, it gave hope to small struggling rural facilities that

they could remain open and fund emergency and diagnostic services on very small numbers. The program offered a hybrid solution.

Current Situation

The Swing Bed legislation allowed some rural hospitals to survive and continue to provide vital healthcare services to their communities. Since the passage of the Affordable Care Act (ACA) in 2010, there has been a downward utilization trend and subsequent cash flow issues in small, rural hospitals. Increased out of pocket expenses for healthcare, associated with high-deductible health plans, have increased significantly over the past two years. This has resulted in patients deciding not to seek care due to the costs, resulting in an ever-increasing private pay Accounts Receivable (AR) burden on the hospital. This issue becomes even more pronounced in the twenty states that have not expanded Medicaid.

Small Rural Hospitals at Risk

According to iVantage Health Analytics, 283 rural hospitals are projected to face significant financial and operational challenges according to their Hospital Strength Index. With 80 million Americans living in rural areas, these 283 at-risk hospitals provide 700,000 patient encounters, 36,000 healthcare jobs, support 50,000 community jobs and provide 10.6 Billion dollars in Gross Domestic Product (GDP). The loss of these hospitals is significant in terms of economic vitality, but also in denying access to Medicare beneficiaries that depend on these facilities for care.³

This Swing Bed program is essential to hospitals that are located in underserved areas with high Medicare utilization. The per-day reimbursement is based on a Facilities Medicare Cost Report and reflects the actual per day costs involved in operating an acute care facility. The

³ "iVantage Knowledge Base." iVantage Health Analytics. <https://www.ivantagehealth.com>

key here that we will address below is the cost of care. What does it truly cost in order for an acute care facility to operate in a rural remote area with low patient volumes?

The OIG Position Paper

In March of 2015, the OIG issued a report on Medicare's expenditures on swing beds in Critical Access Hospitals, entitled *Medicare Could Have Saved Billions at Critical Access Hospitals if Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates*. Their reason for this report was to state that Medicare could have saved billions of dollars by paying CAH hospitals at the Skilled Nursing Facility Prospective Payment System Rates as opposed to the current Medicare cost based reimbursement.⁴

Below are three significant issues identified with the OIG report and its analyses of the Swing Bed program: The first issue found is, the OIG report significantly over-estimates the potential Medicare savings by removing swing beds from Medicare cost-based reimbursement. The OIG used a simple formula of *Average CAH payment per swing bed day – Average SNF payment per bed day X Number of CAH swing bed days*. This simple per diem method ignores the fixed cost transfers between services. Thus it over-estimates the Medicare savings of removing swing beds from cost based reimbursement. In other words, the fixed costs associated with the acute care unit do not change when swing beds are removed from the equation. The fixed cost is simply transferred to other departments, mostly acute care. Therefore, the same fixed costs are now spread over fewer patient days resulting in a higher cost per patient day. The OIG report did not take into account this fixed cost transfer. The North Carolina Rural Health

⁴ Office of Inspector General. *Medicare Could Have Saved Billions at Critical Acc*, (Washington, 2015)

Research Program stated that the estimate of cost savings by the OIG was more than three times too large.⁵

The second issue found is the OIG report states that swing bed days are growing at a rapid rate, between 2005 and 2010, growth of 15.8%. The OIG report suggested that the growth in swing bed days is potentially an abuse of the program. However, during this same period, long-term bed utilization in rural areas increased by 21%. Further, the increase in swing bed utilization in Critical Access Hospitals was due to the growth of Critical Access Hospitals rather than a significant increase in bed utilization per hospital.

The third issue is that the OIG report states that the patient outcomes of swing bed patients are similar to SNF patients. There is very little evidence involving SNF patients versus swing bed patients. However, swing bed status allows for a higher level of care than is available in most rural long-term care facilities. Medically complex patients are often cared for in a swing bed facility until such time that they can go home or to a lesser level of care in a long-term care unit.

The Value of Swing Beds to a Rural Community

The value of a swing bed program to a rural community is dependent on a number of factors such as size of community, geography, demographics, health status, and support systems. One way to better understand the complexities of the swing bed program is to look at one Nevada Critical Access Hospital (CAH). This CAH is 172 miles from a tertiary care hospital. It operates a 30-bed long-term-care (LTC) facility that is almost always full. Prior to the swing bed program, it was not always possible for fragile, at-risk patients needing discharge to go to the LTC facility. Going home often is not an option due to an unsafe environment or lack of support

⁵ Freeman, V.A. and Radford, A., 2012, Why Use Swing Beds? Conversations with Hospital Administrators and Staff. North Carolina Rural Health Research & Policy Analysis Center Findings Brief.

services, including home health care. Initially, hospital personnel were reluctant to turn acute care beds/space into a “nursing home”. However, hospital staff now see the value swing beds provide, a necessary service to the community and the benefits in being able to keep patients in a safe environment while they heal before their discharge to home.

Community Satisfaction

In an evaluation sponsored by the federal government it was found that long-term care patients loved swing beds and that being in a hospital made them feel better cared for. Additionally since they weren’t physically moved to a nursing home, the program was much less disruptive than a move to a nursing home would have been. Families loved keeping grandma in her hometown and not having to travel to a distant nursing home to see her. Physicians liked swing beds because they could visit their patients more frequently than if they were sent to a nursing home. Administrators and nurses came to like swing beds for satisfying the community’s long-term care needs.”⁶

Post-acute centers have long held reputations of being the last resort for the sickest and dying. On the other hand, hospitals are seen as the place to go for treatment and recovery. The perception of wellness translates to the swing bed. Patients prefer swing beds because of the perceived stigma and fear of nursing homes⁷

Findings of ongoing evaluation of the national swing-bed program demonstrate the value the swing-bed program brings to healthcare organizations, communities, and individuals. These findings are highlighted below:

- Improved access to institutional long-term care for residents of rural communities.

⁶ Sharon Begley, *To Improve Health and Healthcare, Volume VI Anthology*, “The Swing-Bed Program”, (San Francisco, CA: Jossey-Bass, 2003), Chapter 11.

⁷ Freeman, V.A. and Radford, A., 2012

- Improving the quality of life of long-term care patients by providing access to care near family and friends and avoiding the trauma of transfer out of the community when unnecessary
- Long-term care patients with more intense medical need have greater access to needed services.
- Swing-bed hospitals were more likely to serve a higher portion of these “heavy-care” patients than nursing homes were.
- A higher proportion of rural residents remain in their communities with swing-bed services than in communities where swing-beds are not available.
- There is a significantly greater proportion of Medicare long-term care days and a slightly higher proportion of private-pay patients in swing-bed hospitals than in community nursing homes.
- Providing better access to medical care and support services such as respiratory therapy and lab services.
- The increased availability of specialized personnel
- The emphasis on development of quality-assurance programs for swing-bed patients has encouraged hospitals to begin or improve these programs for acute patients as well.⁸

The Solution to Access Issues

The swing-bed solution was meant to address two issues impacting rural health systems, which still exist today: “(1) hospitals were built on a scale that often resulted in their having more beds than patients to fill them, and (2) frail elderly people who were disabled often needed to go to nursing homes far from where they lived... As a result, those facilities that did exist typically had a high occupancy rate and a long waiting list, leaving rural residents, especially elderly ones, with little access to long-term care.”⁹ Hospitals often experience difficulty having SNF accept patients on weekends, whereas swing beds are virtually always available, improving access to care.

⁸ Richardson, H. & Kovner, A. "Swing-Beds Current Experience and Future Directions." Health Affairs, 6, no.3 (1987):61-74 . 1987. <http://content.healthaffairs.org/content/6/3/61.full.pdf>

- ~12% of patients from rural hospitals were discharged to facility-based, post-acute care, i.e., a swing-bed or skilled nursing facility (SNF).
- Patient characteristics were comparable regardless of hospital type or post-acute care discharge destination
- Type of rural hospital makes a difference - of patients discharged to post-acute care
 - 96% went to SNFs from rural Prospective Payment System (PPS) hospitals
 - 60% went to SNFs from CAHs
- This difference is likely due, in part, to the regulations that limit swing beds to rural hospitals with fewer than 100 beds and greater availability of SNFs in more populated areas.
- Typical Swing-Bed and SNF Patient Population:
 - Generally elderly, female
 - Multiple chronic conditions
 - Hospitalized for cardiac, respiratory, and orthopedic conditions.
- A decrease in the availability of care in one setting will have an impact on the availability of care in the other, which is a particular concern in rural areas where swing beds are the only form of post-acute care.¹⁰

According to the National Rural Health Association, 80 million rural Americans rely on rural health providers. Swing beds remain the only option for post-acute skilled care in the most rural areas. While other communities have options, the availability and choice are limited. In 2008, 4.1% of the population in non-CBSAs resided in counties where the only access to post-acute skilled care was through swing beds. The state of Nebraska has 63 Rural Critical Access Hospitals. While 100% of these hospitals offer swing bed services, only 19 (30%) of these hospitals offer Long Term Care services to their communities, 54 communities have independent

¹⁰ V. Freeman, RN, DrPH; R. Randolph, MRP; M. Holmes, PhD. *"Discharge to Swing Bed or Skilled Nursing Facility: Who Goes Where?"* Sheps Center for Health Services Research The University of North Carolina at Chapel Hill. Feb 2014.

long term care facilities, and 5 (7.9%) of communities with CAH's have no post-acute options other than their swing bed.¹¹

“Rural Americans are older, poorer and sicker than their urban counterparts... Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider.”¹². Swing beds are uniquely set up to care for this older, poorer, and sicker population.

1. Interchangeability of acute beds and post-acute care, swing beds allows for care of the sicker patients. Post-acute patients with needs including; ventilator care, bariatric care, dialysis, IV antibiotics, etc. can continue to receive this specialized services that other post-acute centers refuse. Medically complex patients were more likely to be cared for in their swing beds than in their local SNFs. Specialized equipment needs are not a barrier to care in the hospital swing bed setting. The specialized patient care and equipment needs cannot be adequately reimbursed through traditional nursing home resource utilization group (RUG) payments while they can be captured in CAH payments.¹³
2. Swing bed staffing is another benefit in caring for the sicker or medically complex patient. Critical Access Hospitals rotate their staff between inpatient and swing bed units. These hospitals utilize a majority of RN staff to maintain hospital CMS compliance. On the other hand, “RN's provide the least direct patient care in nursing homes relative to other settings; most direct care is provided by LPN's and NA's”¹⁴.

¹¹ Reiter, K.L. & Freeman, V.A. (2011). Trends in Skilled Nursing Facility and Swing Bed Use in Rural Areas Following the Medicare Modernization Act of 2003. The North Carolina Rural Health Research & Policy Analysis Center.

¹² HHS, 2011

¹³ Freeman, V.A. & Radford, A., 2012

¹⁴ Corazzini, K.N., Anderson, R.A., Rapp, C.G., et. al., 2010

Further studies show that less than 15% of the nursing staff in nursing homes are RN's. The skilled nursing available in CAH's prevents the skilled patient from having to be transferred to a large acute care center where the cost of care is higher.

3. The majority of Critical Access Hospitals are Not for Profit and they do not discriminate based on the patient's ability to pay. Most hospital mission statements include a charitable purpose statement. Hospitals are the primary care center for the homeless, uninsured, under-insured or non-covered insured.

Quality of Care

Measuring quality is an essential part of value-based care. Even though swing-beds and SNF's provide services to comparable populations, it's difficult to compare the quality of one against the other, largely related to the way data is collected and coding is done. Medicare's skilled nursing facility prospective payment system (SNF PPS) is tied to resource utilization groups, Version IV (RUG-IV) coding. This coding is related to data collected from the Minimum Data Set (MDS) Assessment. Information derived from the MDS can also be used to measure quality. CAH swing beds are exempt from using MDS and RUG-IV coding. CMS determined the MDS posed a compliance burden to CAHs, "which could be reduced without jeopardizing patient safety or health. CMS clarified that CAHs are required to complete a resident assessment and a comprehensive care plan for each Swing Bed patient and document the assessment in the patient's medical record.¹⁵ Interestingly, non-critical access hospital swing bed facilities are required to use Medicare's MDS 3.0. "The MDS is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes (NHs) and non-

¹⁵ CMS.gov." Centers for Medicare and Medicaid Services. 6 Mar 2015. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html>

critical access hospital swing beds (SBs).”...MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NH (nursing home) and SB (swing bed) care and public policy. Enhanced accuracy supports the primary legislative intent that MDS be a tool to improve clinical assessment and supports the credibility of programs that rely on MDS.”¹⁶

Readmissions

Medicare’s Hospital Readmission Rate Reduction Program (HRRRP) highlights the importance of integrating healthcare with the community, and coordinating care across the healthcare continuum. Though exempt from HRRRP, CAH’s with swing beds can still impact readmission rates for other acute hospitals by providing local LTC for a patient where homecare or a SNF may not otherwise be available. The rural swing bed option can be used as a valuable utilization management option. CAHs and rural communities are acutely aware of their limited resources, and work hard to provide the highest quality healthcare locally whenever possible; swing beds enhance that capability. Imagine the elderly farmer, who fell and broke his hip. He’ll be able to receive LTC at the local CAH swing bed, instead of being transferred to a SNF, likely not located in his rural region. He’ll benefit from having supportive family and friends nearby. Friends and family won’t have the added financial and time burden of driving to a SNF.

A large urban medical center in Nebraska has been tracking readmissions for the 18 months prior to October 2015. The findings were that out of 313 total readmissions, only 3 of these patients were readmitted from a CAH swing bed. This equates to less than 1% of

¹⁶ CMS.gov., 2015

readmissions occurred from patients who were sent to swing beds verses home and independent SNFs. Further studies will be needed to determine if this is a national trend.

Length of Stay Concerns

Hospital length of stay differed with shorter stays for patients in CAHs compared to rural PPS hospitals. Patients discharged to swing beds had also had shorter stays than those discharged to SNFs regardless of hospital type (0.9 days shorter for CAH, 1.1 days for PPS). The similarities in the characteristics of patients served in both types of care suggest that swing beds and skilled nursing facilities are substitutes for each other.

Specialty Services

With decreasing inpatient numbers, CAH's depend on growing their specialty services. Orthopedic Knee Replacement surgeries have proven a safe and successful specialty service to offer the rural community locally. The ability for patients to remain in the hospital swing bed for their rehabilitation is a contributing factor when determining whether specialties will perform procedures locally or pull those patients back to the metropolis. Additionally, recovery time in a swing bed is a full day shorter than a PPS skilled nursing facility according to the Sheps Center at the University of North Carolina.¹⁷

A further advantage of CAH swing beds is continuity of care for their inpatients. Keeping the patient within the hospital walls allows you the safety net of knowing what type of care the patient continues to receive, the staff taking care of the patient, the protocols driving the patient care, etc.

¹⁷ Freeman, V.A., Randolph, R.K., Holmes, M. (2014). Discharge to Swing Bed or Skilled Nursing Facility: Who Goes Where? Findings Brief: The North Carolina Rural Health Research & Policy Analysis Center.

Summary

The Medicare Swing Bed Program has positively impacted patients' lives for over thirty-five years. Patients have been able to recover from surgery and illness in their hometown in a safe and secure environment. These human impacts are significant and long lasting. The rural hospitals that have swing beds have benefitted financially due to the Medicare cost-based reimbursement provided. Due to this enhanced reimbursement, some small rural facilities have been able to remain open and serve their communities.

The high fixed costs in acute care hospitals drives the reimbursement rate. Without appropriate reimbursement, at least 283 facilities are in danger of closing and impacting care for millions of patients. CMS and the OIG need to be reminded of the responsibility that they have to rural America.

Policy Implications

As a result of the finding in this paper the NRHA issues the following position statements:

- Swing beds are essential for the continuity of care for seniors and high medical need residents in rural America.
 - Swing beds prevent costly and unnecessary transfers to higher cost acute care centers.
 - Swing beds allow for skilled rehabilitation locally.
 - Swing beds keep families local and together in times of medical crisis by preventing families from the burden of hundreds of miles of travel.
- Closing swing bed capability will further stress the economics of rural America by causing families to move to urban centers.

- The NRHA supports continuation of the Swing Bed Program as currently operated.
- The NRHA rejects the conclusions of the OIG report for the following reasons- .
 - The removal of swing beds will cost the government more money than it will save.
 - The cost of transferring and caring for these patients in urban acute care centers is higher than in rural CAH swing beds.
 - Lengths of stays are shorter in swing beds than in LTC beds.

Further Study Needed

Further analysis is required in order to evaluate the impact on the rural healthcare system.

Topics for further consideration include:

- The potential impact of ACO's on Swing Beds and rural hospitals.
- The potential impact of bundled payments on Swing Beds and rural hospitals.
- The potential impact on Medicare recipients in rural areas if the Swing Bed option goes away.
- The potential impact on rural hospitals due to the lack of quality reporting and scoring in Critical Access Hospitals as opposed to freestanding nursing homes.
- The availability in rural areas of LTC beds for acutely ill hospital discharges.
- The ability of CAH's to care for the acutely ill patient. Are length of stays shorter? Fewer subsequent emergency department visits and hospital readmissions?

- Financial modeling needs to be completed regarding the true and total cost of care throughout the healthcare continuum. This includes pre-hospital care, emergency room, acute care, rehabilitation and long-term care.
- Financial and non-financial analysis on the impacts to a rural community should the local hospital fail as a result of the discontinuance of the Swing Bed program.

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