Post-COVID Swing Bed Opportunities

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PHE Flexibilities Impacting Swing Bed Utilization

- 96-hour payment rules
  - Per 42 USC 1395f(a)(8), admitting physician must certify in writing that patient expected to be discharged or transferred within 96 hours of admission
    - In 2018, CMS deprioritized enforcement of this requirement due to administrative burden
  - Per 42 CFR § 485.620(b), CAH must maintain annual average acute care inpatient LOS ≤ 96 hours
    - CMS waived this CoP for duration of PHE
    - Post-PHE enforcement?
- Qualifying hospital stay requirement (3-day rule)
  - CMS waived this qualification for SNF/swing bed admission for duration of PHE (beneficiary still must require SNF/swing bed level of care)
- PPS hospital swing beds
  - PPS may seek MAC authorization to provide post-acute care in acute care bed (discharge and re-admit)

Swing Bed Opportunities

Short term: Increase CAH swing bed admissions to improve financial position by increasing revenue and stabilizing staffing

Longer term: As swing bed programs grow, pursue opportunities to develop specialized services further secure these hospitals' financial position

- E.g., wound care, respiratory support, intravenous treatment, cardiac monitoring, pain management, complex tube feedings

Obstacles to Swing Bed Utilization

1. Objections Based on Cost

PPS hospital participating in shared savings arrangement or episodic payment model concerned that swing bed daily rate higher than SNF rate

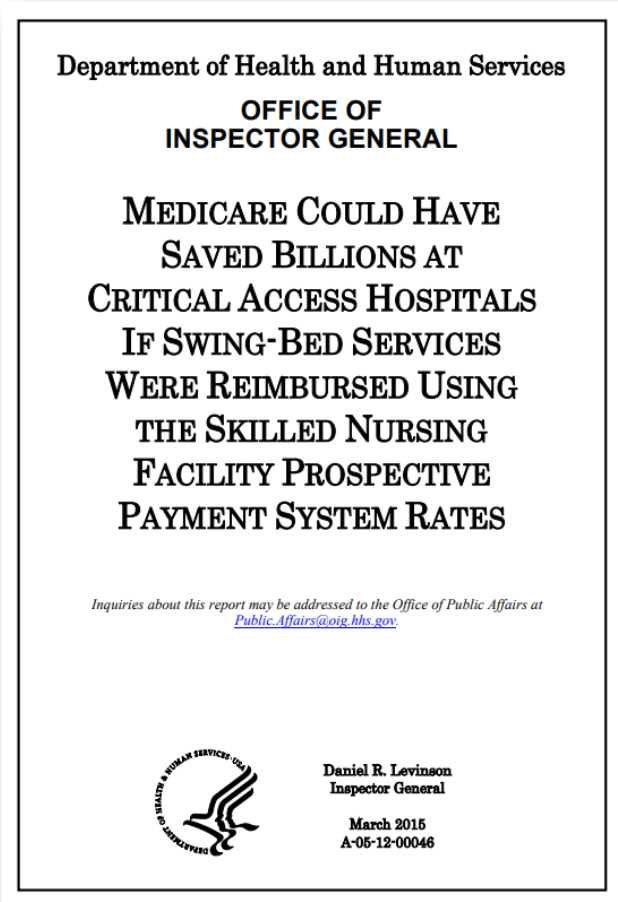
2. Perceptions Regarding Quality of Care

PPS hospital assumes SNF specializes in post-acute care and thus provides higher quality of care

3. Hassle Factor

PPS hospital case managers have experienced difficulties in arranging transfers to close-to-home facilities and thus default to local SNF

1. Objections Based on Cost



Department of Health and Human Services

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

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

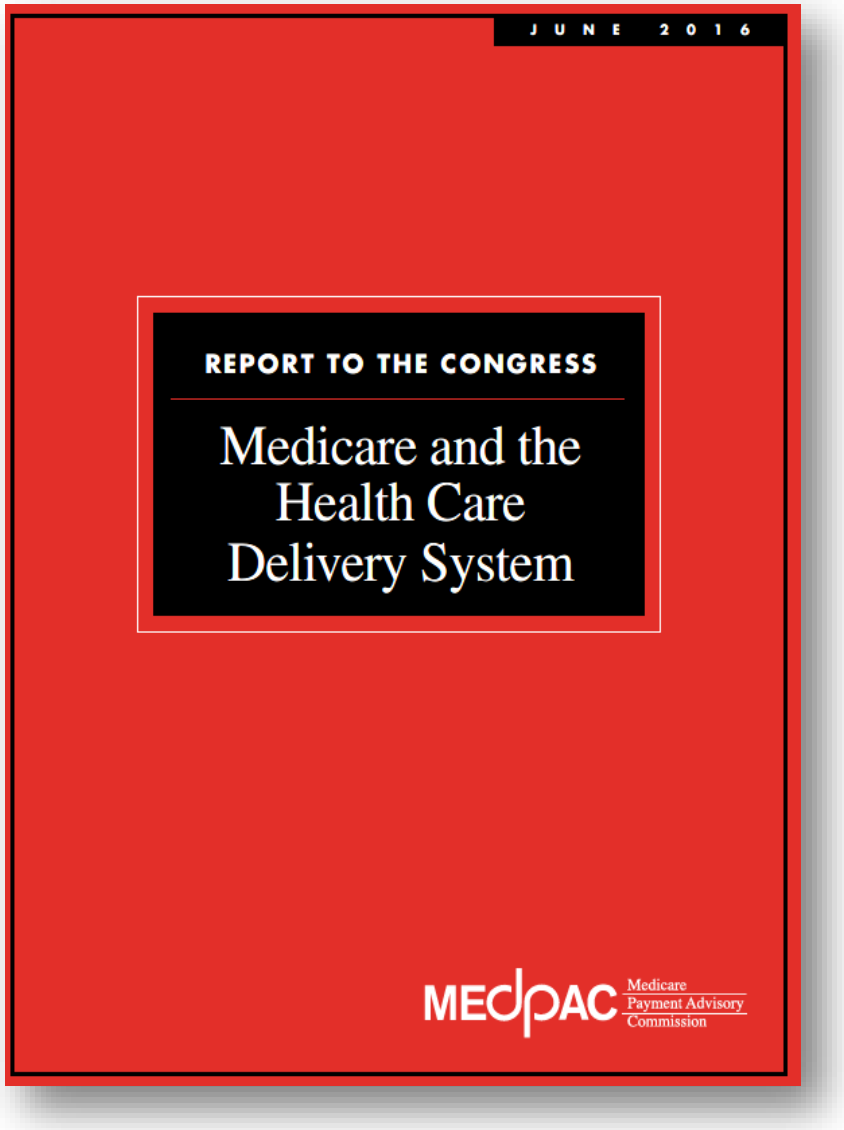
Daniel R. Levinson
Inspector General

March 2015
A-05-12-00046

" We estimated that Medicare could have saved $4.1 billion over a 6-year period if payments for swing-bed services at CAHs were made using SNF PPS rates."

{ Average CAH per diem payment per swing bed day — (MINUS) Average SNF payment per day } X (TIMES) Number of CAH swing bed days

"Medicare pays substantially more for a post-acute day in a CAH swing bed than a [SNF]. In 2013, Medicare paid the median CAH $1800 per post-acute swing bed day. This amount is $1,400 higher than the $400 per day paid to SNFs on average."



More of the Same?

Swing-Bed Services at Nationwide Critical Access Hospitals

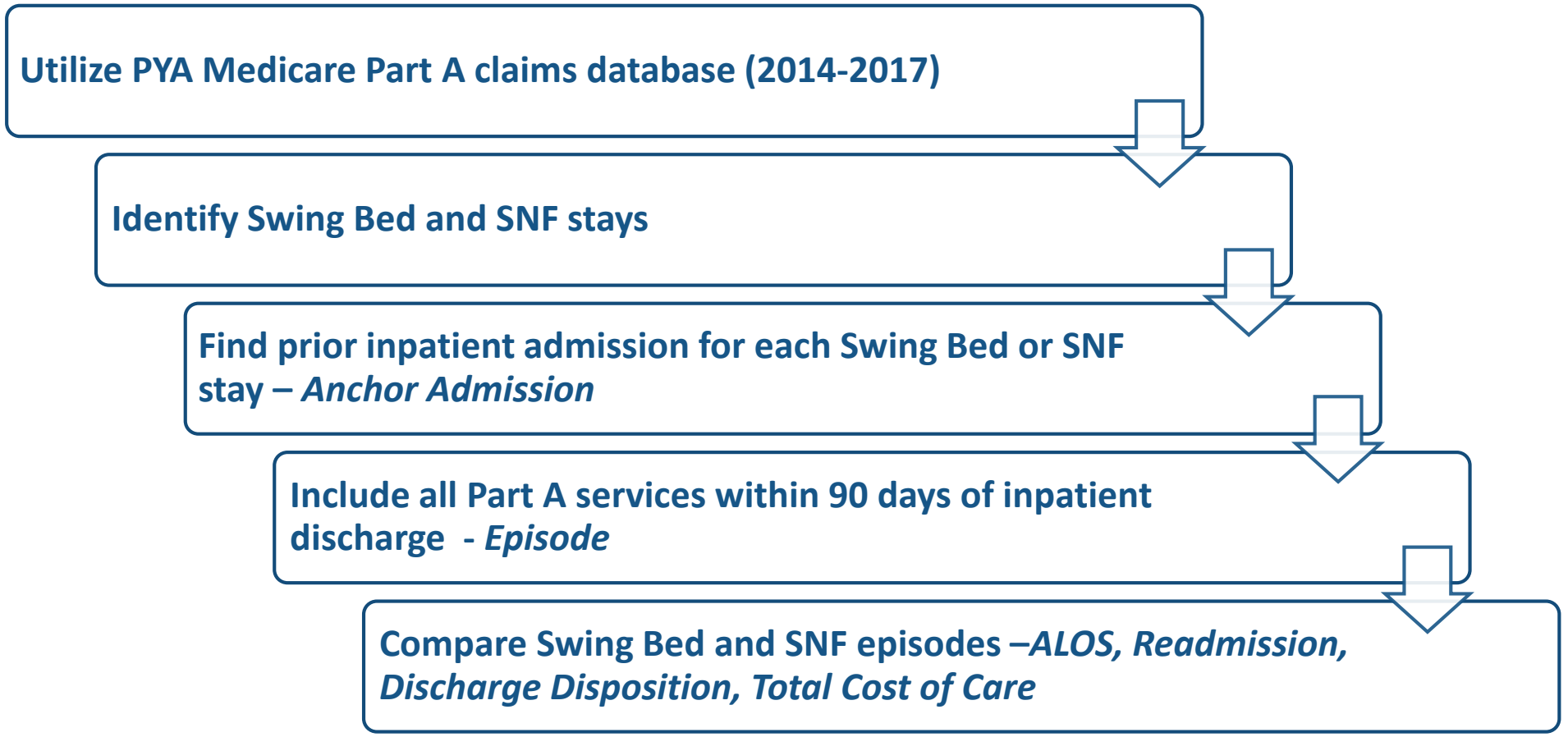
In 2015, the Office of Inspector General reported that swing-bed usage at Critical Access Hospitals (CAHs) significantly increased from CY 2005 through CY 2010. Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. We estimated that Medicare could have saved $4.1 billion over the CY 2005 through CY 2010 period if payments for swing-bed services at CAHs had been made using Skilled Nursing Facility Prospective Payment System rates. We will review swing-bed data for CY 2015 through CY 2019 to determine whether: (1) any actions were taken to reduce swing-bed usage at CAHs; (2) Medicare payment amounts were updated for swing-bed services to CAHs; and (3) alternative care was available to Medicare beneficiaries at a potentially lower rate.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
Revised	Centers for Medicare and Medicaid Services	Swing-Bed Services at Nationwide Critical Access Hospitals	Office of Audit Services	W-00-20-35853	2023

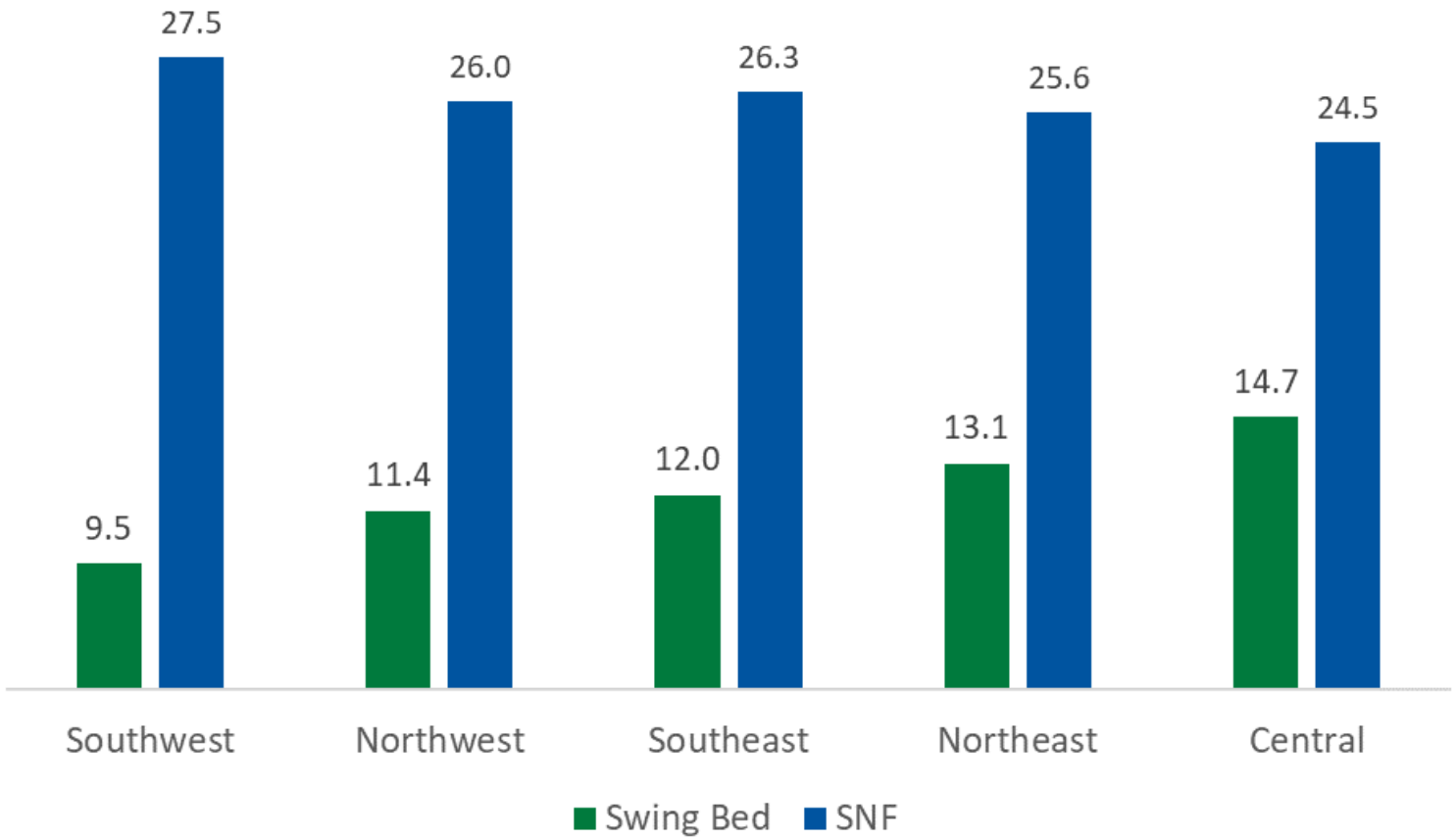
Apples-to-Apples Comparison

- Swing bed LOS is significantly lower than SNF LOS
- Swing beds have significantly lower readmission rates than SNFs
- The total cost of care for the post-discharge period for swing bed patients is *slightly* higher than the cost for SNF patients
  - And even that difference may be negated when additional Part B expenses associated with SNF stays taken into consideration

Part A Claims Analysis - Methodology

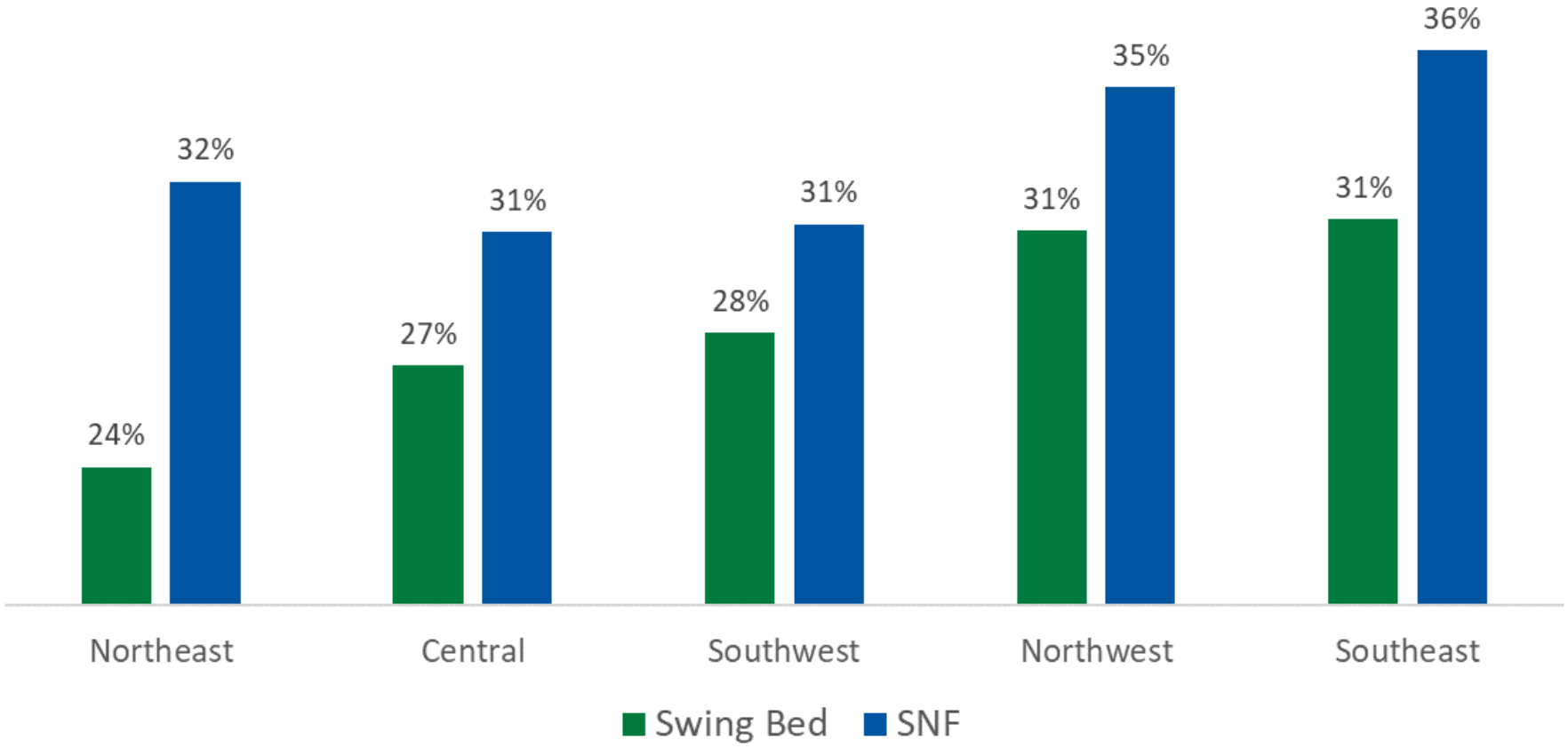


MO Regional Comparison – ALOS Per Discharge



On average, wwing Beds stays are ***~14 days less*** than SNF stays

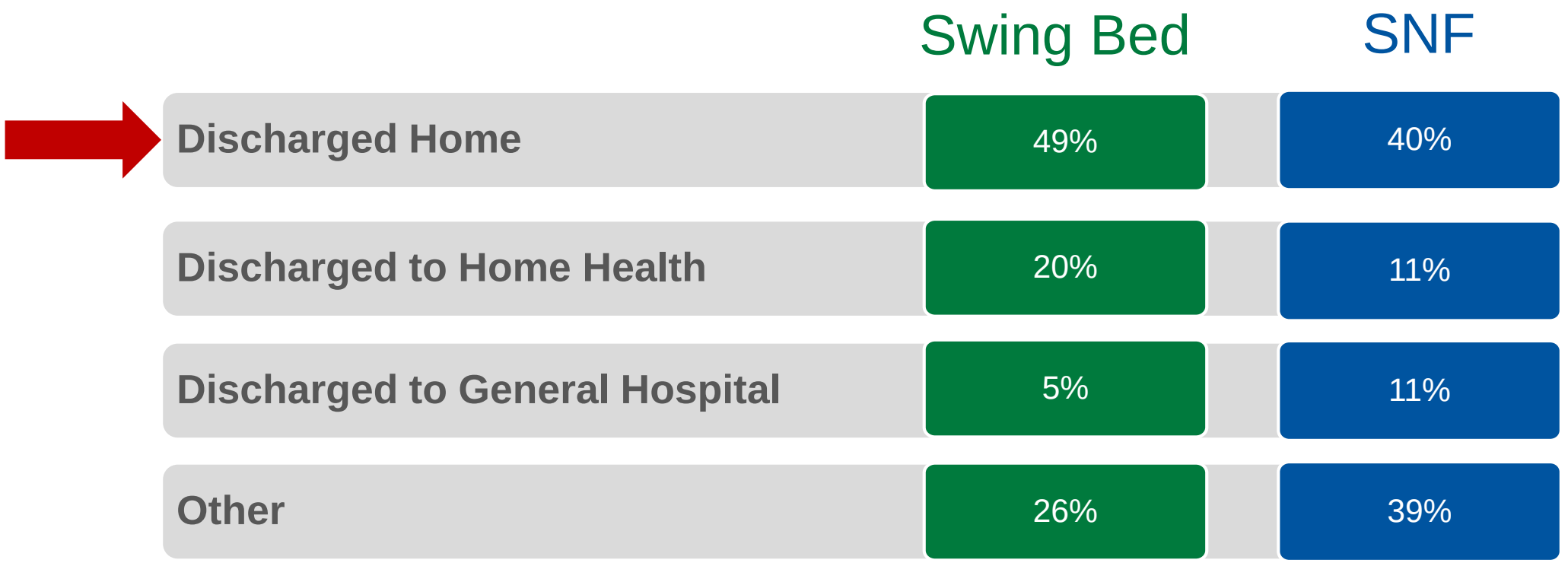
MO Regional Comparison – Readmission Rate



On average, swing beds have approximately

5% lower readmission rates than their SNF peers

MO Discharge Disposition Comparison



MO Total Cost of Care By Admitting Diagnosis

			Average			
Swing Bed Admitting Diagnosis Code	Diagnosis Description	Episode Volume	IP Anchor LOS	Swing Bed LOS per Episode	Swing Bed Total Cost of Care	SNF Total Cost of Care
V5789	Rehabilitation proc NEC	833	5.5	14.5	$40,700	$31,378
V571	Physical therapy NEC	214	5.3	15.1	$40,158	$31,615
486	Pneumonia, organism NOS	130	4.2	11.2	$25,772	$27,275
78079	Malaise and fatigue NEC	76	6.2	11.6	$33,019	$28,404
5990	Urin tract infection NOS	53	4.4	13.5	$26,854	$26,841
V660	Surgical convalescence	43	5.5	10.6	$35,094	$18,701
49121	Obs chr bronc w(ac) exac	37	4.5	12.5	$29,984	$26,316
4280	CHF NOS	34	5.2	11.3	$32,165	$29,180
78605	Shortness of breath	26	4.2	9.9	$32,349	$31,882
V5481	Aftercare joint replace	23	3.3	9.7	$21,612	$28,003
6826	Cellulitis of leg	19	4.2	8.5	$25,622	$26,581
43491	Crbl art ocl NOS w infrc	16	4.3	12.9	$36,443	$36,894
V664	Fracture treatmnt conval	14	5.2	16.9	$45,465	$34,868
5070	Food/vomit pneumonitis	14	5.8	7.4	$28,252	$30,892
0389	Septicemia NOS	14	4.1	12.8	$31,177	$32,587

SNF Part B Expense

- Patient with severe headache requires CT scan
  - SNF: Excluded service under the SNF PPS consolidated billing requirements = additional Part B expense (not part of $400/day)
  - CAH Swing Bed: Must include on swing bed claim, regardless of reason for service, findings, or if additional services were required (included in $1400/day)

Medicare Post-Acute Care Transfer Policy

- When PPS hospital patient with LOS < geometric mean is transferred, hospital receives per-diem rate (for specified MS-DRGs)
  - Skilled nursing facilities
  - Inpatient rehab facilities and units
  - Long term care hospitals
  - Psychiatric hospitals and units
  - Children's and Cancer hospitals
  - Home with a home health plan of care that begins within 3 days
  - Hospice care
- Does NOT apply to swing bed transfers

Inpatient Post-Acute Care Transfer Adjustment

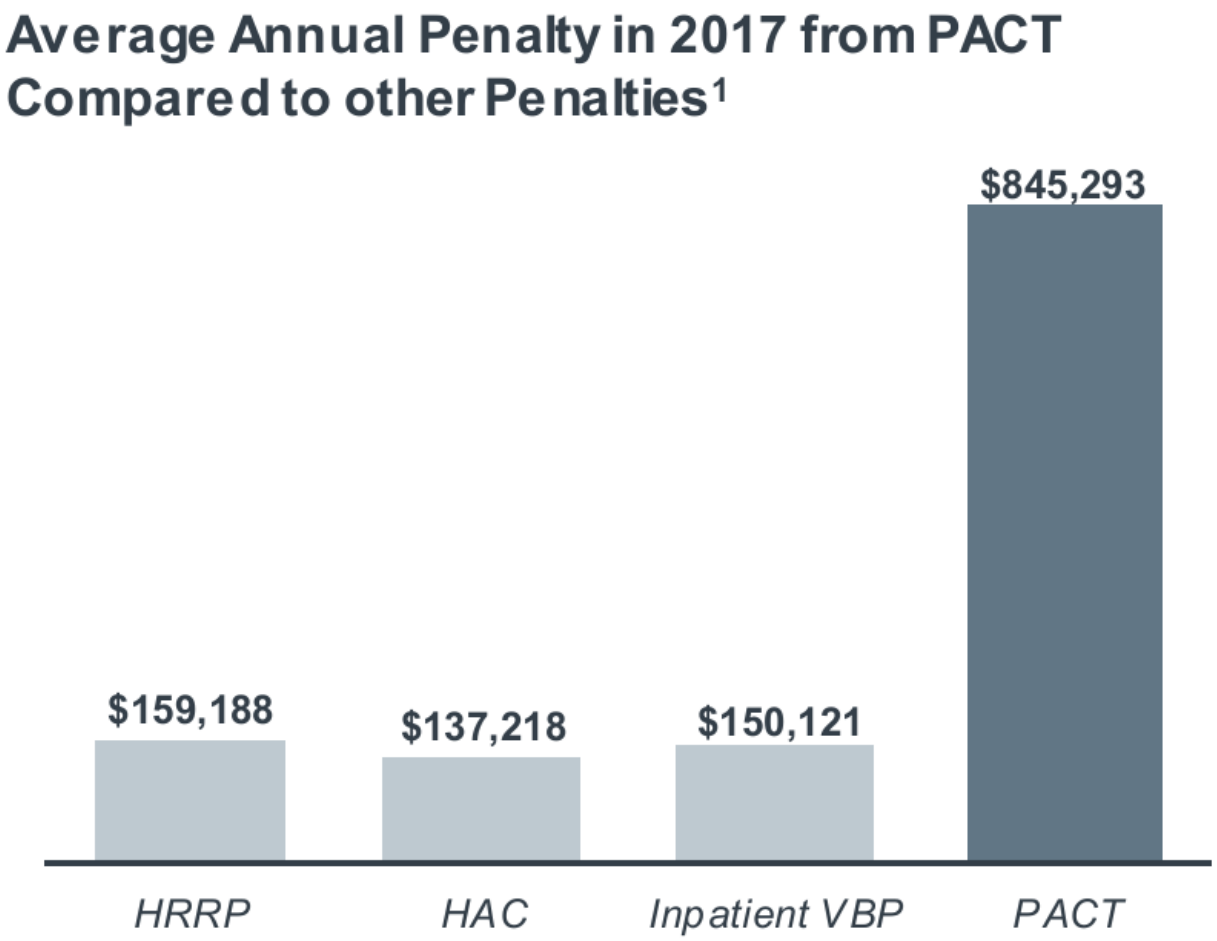
Community Medical Center

Estimated Impacts by Discharge Setting

	FFY 2019		FFY 2020		FFY 2021	
Estimated Yearly Revenue	**$18,465,900**		**$17,256,700**		**$17,192,900**	
Discharge Setting	**Est. Impact**	**Impact %**	**Est. Impact**	**Impact %**	**Est. Impact**	**Impact %**
Skilled Nursing Facility	($60,600)	-0.33%	($53,600)	-0.31%	($53,500)	-0.31%
Cancer & Children Hospitals	$0	0.00%	$0	0.00%	$0	0.00%
Home Health	($74,100)	-0.40%	($64,600)	-0.37%	($61,100)	-0.36%
Inpatient Rehabilitation Facility	($44,300)	-0.24%	($41,600)	-0.24%	($42,000)	-0.24%
Long-Term Care Hospital	($3,800)	-0.02%	($1,800)	-0.01%	($2,900)	-0.02%
Inpatient Psychiatric Facility	($1,900)	-0.01%	($1,800)	-0.01%	($1,900)	-0.01%
Hospice	($28,900)	-0.16%	($27,700)	-0.16%	($28,600)	-0.17%
Total Impact	**($213,600)**	**-1.16%**	**($191,100)**	**-1.11%**	**($190,000)**	**-1.11%**

Impact %s are calculated using estimated yearly revenue before PACT adjustments

PACT's Impact on PPS Hospitals



1) The Advisory Board (2018)

2. Perceptions Regarding Quality of Care

- Hospital readmission rates
- Length of Stay
- Return to community
- Process of care/teamwork
  - Staffing levels
  - Lab and radiology
- Patient experience of care/patient satisfaction
- Adverse events (infections, falls, pressure ulcers, use of antipsychotic medications)
- Functional status
  - Need for assistance with activities of daily living (initial assessment vs. discharge)

Swing Bed Value Equation

- Hospital readmission ✓
- Return to community ✓
- Average LOS ✓
  - Beneficiary out-of-pocket
- Process of care/teamwork ✓
  - Staffing levels
  - Lab and radiology
- Adverse events
  - Infections, falls, pressure ulcers, use of antipsychotic medications
- Patient experience of care/patient satisfaction
- Functional status
  - Need for assistance with ADLs (initial assessment vs. discharge)

SNF Quality Measures

- SNF Quality Reporting Program
  - Requires SNFs to submit patient assessment data (MDS 3.0)
  - Failure to submit = 2% cut to Annual Payment Update
  - Does not apply to CAH swing beds
- SNF Value-Based Purchasing Program
  - SNF 30-Day All-Cause Readmission Measure
  - 2% withhold re-distributed based on performance
  - Does not apply to CAH swing beds
- Nursing Home Compare
  - Does not include CAH swing beds

Swing Bed → Transitional Care

- High quality post-acute care for challenging patient populations
  - Wound care, respiratory support, intravenous treatment, cardiac monitoring, pain management, complex tube feedings
- Benefits
  - Community hospital setting (vs. nursing home)
  - Closer to family and friends
  - Focus on successful return to home
  - Integration with referring acute care hospital

3. Overcoming Hassle Factor

1. Self-assessment of performance
   - Claims data analysis
   - Documentation of adverse events
   - Patient satisfaction surveys
2. Self-assessment of capabilities
   - Available resources to provide transitional care
   - Willingness of local providers
   - Admission process
   - Transportation

3. Market analysis (potential opportunity)
   - SNFs (compare performance)
   - PPS hospitals (demonstrate savings)
4. Business plan
   - Necessary resource investment to pursue opportunities
5. Partner recruitment
   - Don’t expect anyone to come knocking on your door – compelling case
   - Make it easy

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