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Why Do Some Critical Access Hospitals Close Their Skilled Nursing Facility Services While Others Retain Them?

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Flex Monitoring Team Briefing Paper No. 32

Why Do Some Critical Access Hospitals Close Their Skilled Nursing Facility Services While Others Retain Them?

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

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Monitoring
Team**

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The Flex Monitoring Team is a consortium of the Rural Health Research Centers located at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. Under contract with the federal Office of Rural Health Policy, the Flex Monitoring Team is cooperatively conducting a performance monitoring project for the Medicare Rural Hospital Flexibility Program (Flex Program). The monitoring project is assessing the impact of the Flex Program on rural hospitals and communities and the role of states in achieving overall program objectives, including improving access to and the quality of health care services; improving the financial performance of Critical Access Hospitals; and engaging rural communities in health care system development.

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The Medicare Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (Flex Program), created by Congress in 1997, allows small hospitals to be licensed as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. To participate in the Flex Grant Program, States are required to develop a rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves the quality of and access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate eligible rural hospitals as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services).

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

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Introduction

During the 1980s and 1990s, regulatory and reimbursement changes led rural hospitals to diversify their service mix by adding skilled nursing facility (SNF) and other long term care (LTC) services (See Appendix 1 for terms and definitions).^{1,2} In 1997, the Balanced Budget Act (BBA) reversed this trend by extending prospective payment systems (PPS) to SNF/swing bed, home health, rehabilitation facility, and outpatient hospital services. Following implementation of SNF/swing bed PPS, some rural hospitals and CAHs began to divest themselves of their SNF and/or other LTC services. These closure decisions had unknown consequences for the availability and accessibility of SNF and LTC services in rural areas.³ Other hospitals, however, chose to retain their LTC units and services. Little is known about the reasons CAHs decide to close or retain their LTC services. This briefing paper addresses this gap by examining the factors related to operation of skilled nursing services by CAHs, and specifically the factors related to closure of skilled nursing units by some CAHs and the continued provision of these services by others.

Policy Background

Changing Trends in the Provision of Hospital-based SNF and Other LTC Services

Growth in skilled nursing and other LTC services occurred during the 1980s and early 1990s, as rural hospitals diversified their service lines in response to growing elderly populations in rural communities, stagnant demand for traditional inpatient services, and the changing regulatory and reimbursement environment.^{1,2} The provision of skilled nursing services, in particular, became an attractive option for many rural hospitals by providing an opportunity to reduce inpatient length of stay using a service that, unlike inpatient services, continued to be reimbursed on a cost basis.^{1,4} By 1997, 35% of all rural hospitals provided skilled nursing services in distinct part units.⁵

The implementation of the Medicare SNF prospective payment system (PPS) in 1998 reversed the financial benefits of operating a hospital-based SNF unit by eliminating the ability of hospitals to shift some of their overhead to their SNF units and imposing the same need to control costs and manage SNF bed lengths of stay that applied to acute care beds under PPS. The issue of cost control is a challenge for hospital-based SNFs in that they typically admit more complex patients than do freestanding SNFs and have higher costs.⁶ In response to policymakers' concerns regarding the higher costs of hospital-based SNF care, the calculation of SNF PPS rates do not explicitly recognize all of the higher costs of hospital-based SNF care.⁶ Not surprisingly, the number of all hospital-based SNFs (rural and urban) declined after the implementation of the SNF PPS from a high of 2,100 in 1998 to 1,400 in 2004.⁶

From 2004 to 2008, the percentage of CAHs offering SNF services continued to decline by 4.4%.³ Despite this observed decline in the provision of SNF services by CAHs, a significant number (42% of 1067 CAHs participating in the 2010 American Hospital Association Annual Survey of Hospitals) continued to provide these services notwithstanding the reimbursement policies for acute care, SNF, and swing bed services. Medicare's eligibility and coverage policies are the same for skilled nursing care provided in either a SNF or swing bed.⁷ For practical purposes, the differences between services provided in either type bed should be imperceptible to the patient. For CAHs, the primary differences are financial (i.e., swing beds in a CAH are reimbursed on a cost basis) and administrative (i.e., how the services are billed and the fact that swing beds in a CAH are exempt from the Centers for Medicare and Medicaid Services' Minimum Data Set reporting requirements).^{8,9}

Role of SNF and Swing Beds in Managing Inpatient Lengths of Stay

SNF units allow CAHs and other hospitals to manage inpatient acute care lengths of stay by providing an option to care for patients needing short-term 24 hour per day skilled nursing care and rehabilitation services for recovery from knee and hip replacements, stroke, pneumonia, strokes, or other conditions.¹⁰ Medicare covers up to 100 days of SNF care for each spell of illness after a medically necessary inpatient stay of three days or more.¹⁰ The swing bed program allows rural hospitals to use empty hospital beds interchangeably as either acute care or skilled nursing facility beds based on hospital census levels and patient needs.

Impact of Swing Beds on the Provision of SNF Services by CAHs

The implementation of the SNF PPS (which applied to SNF-level services provided in swing beds as well as freestanding and provider-based SNF units) had a chilling effect on the use of swing beds, particularly for CAHs as the operation of CAH swing beds "pulled" fixed and overhead costs away from cost-reimbursed acute care beds thereby reducing acute care reimbursement. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 exempted CAH-based swing bed services from the SNF PPS (American Hospital Association, 2012).¹¹ The return of CAH swing beds to cost-based reimbursement created additional incentives for CAHs, particularly those operating at lower acute care census levels, to close their SNF units in favor of using swing beds to provide SNF-level services.

Factors Influencing Hospital Decisions Regarding Hospital-Based SNF Units

Under a contract with the Medicare Payment Advisory Commission (MedPAC), Liu and Jones⁶ studied the factors influencing hospitals' decisions to close or retain their SNF unit. They

interviewed administrators from a convenience sample of 15 primarily urban hospitals that had operated hospital-based SNF units prior to the implementation of SNF PPS in 1998. Based on these interviews they identified several factors related to SNF unit closure including:

- Financial losses from operation of the SNF unit;
- The need for additional acute care beds;
- Burdensome SNF survey and certification process; and
- Difficulties maintaining high staffing levels.

Hospitals that continued to operate SNF units cited the following reasons:

- The ongoing need to manage inpatient costs under acute care DRG payments;
- The difficulties experienced by the hospitals in arranging access to community-based SNF services for medically complex patients; and
- Meeting the broader needs of their physicians, patients, and communities.

Flex Monitoring Team SNF Study

Although Liu and Jones's⁶ work provided insight into issues related to the operation of SNF units by CAHs, variations in reimbursement policies and swing bed use suggest that the incentives influencing the decisions of CAHs regarding their SNF units may differ from those of urban hospitals. Based on a review of the literature and conversations with members of the Flex Monitoring Team's Expert Work Group, we expected the financial decision regarding SNF unit operation to be more complex for CAHs than for PPS hospitals largely because the decision involves the profitability of a PPS-reimbursed SNF within a cost-based facility. In the case of the CAH, the indirect and facility costs associated with operating a PPS-reimbursed SNF unit must be subtracted from the cost base of the cost-reimbursed acute care services thereby reducing reimbursement for those services. We also expected that the availability of swing beds (which can be used effectively to manage acute care length of stay issues without compromising acute care reimbursement) would be a significant factor in decisions to close SNF units. Based on our conversations with members of the Expert Work Group and a review of the literature, we identified other factors that might influence a CAH's decision to retain a SNF unit including: the need for an alternative to swing beds to manage length of stay issues for CAHs with consistently high acute care census levels; community need and preference (which might be particularly important for municipal and county-owned hospitals); and limitations on SNF unit closure imposed by state Certificate of Need regulations. Among the potential factors influencing a CAH's decision to close or retains its SNF units, only the latter factor (i.e., the influence of Certificate of Need regulations) was not supported by our study.

Using a similar approach as Liu and Jones, we interviewed 20 CAHs operating in eleven states, including 11 hospitals that had closed their SNF units and 9 that continued to operate their services (Appendix 2).¹ Characteristics of the hospitals participating in this study are described in Appendices 3 and 4. The following highlights our study findings.

SNF Closure Findings

Factors Influencing SNF Closure: The study hospitals' decisions to close their SNF units focused primarily on the poor financial performance of these units caused by a complex mix of financial issues including:

- Low SNF reimbursement rates from Medicare and, in many cases, Medicaid;
- Higher operating costs due to greater staffing levels, assumption of hospital overhead, increased diagnostic, therapy, and pharmaceutical use, higher patient acuity, and longer lengths of stay;
- The negative impact on acute care reimbursement rates due to the need to allocate facility and overhead costs away from acute care services to the PPS-reimbursed SNF beds; and
- The ability to substitute cost-based swing beds for PPS-based SNF beds.

The issue did not seem to be one of utilization as most reported that the census rates for their SNF units were generally high prior to closure. In some cases, SNF unit financial performance was complicated by the fact that the beds were dually certified for SNF and nursing home/intermediate level services. Those units with dually certified beds noted low Medicaid reimbursement rates for nursing home/intermediate levels of care, particularly in light of the higher costs associated with a hospital-based service.

A limited number reported that management and staffing issues contributed to their decision to close their units. One noted the greater regulatory and reporting requirements for SNF units, specifically the requirement that the Minimum Data Set assessment tool be completed for SNF unit patients. Swing bed patients are exempt from this reporting requirement. In a small number of cases, respondents reported that plans to construct replacement facilities contributed to their closure decisions. One respondent stated that, in addition to financial concerns, the closure of his hospital's nine bed SNF unit allowed the hospital to convert those beds to swing bed use and expand bed capacity to the maximum allowable 25 beds.

¹ The eleven states included: Iowa, Indiana, Illinois, Kentucky, Maine, Minnesota, Montana, North Carolina, Oregon, Washington, and Wisconsin.

Impact of SNF Closure on SNF Access: CAHs that closed their SNF units reported few difficulties accessing SNF and other LTC services following closure, particularly for lower complexity patients. Overall, the availability of alternative local services supported hospitals' decisions to close their SNF units. Only one respondent noted that his hospital experienced periodic difficulty arranging placement for patients. He explained that the board considered this possibility as it tried to balance community needs against fiscal stability of the CAH. None of the respondents reported any negative impact on their acute care length of stay or their ability to manage acute care census due to the closure of their SNF units. In general, SNF, nursing home, residential, and other LTC services, some owned by the hospitals, were available in their communities or located within a reasonable distance in surrounding communities.

In a limited number of cases, the hospitals closed their SNF units but retained lower intensity nursing home, custodial, or residential care. One CAH had closed its SNF unit but retained twenty beds for LTC services, six of which were licensed for intermediate level care and fourteen which were retained as custodial care beds for private pay patients. The hospital subsequently closed the intermediate beds due to low Medicaid reimbursement rates, licensing and insurance costs, and the regulatory burden of a separate survey process for those beds. The intermediate beds were described as a big "financial drain". The hospital believes it has honored its commitment to the community to retain "nursing home" capacity through the continued operation of its custodial care beds.

Some respondents reported that the adoption of an early discharge planning process helped minimize delays in arranging a placement when a patient is ready for discharge. However, other respondents noted that the placement of patients with complex needs involving dementia or other cognitive issues or patients without health insurance remained a challenge, despite the availability of alternative local services. Placement for these patients often requires travel to more distant services.

Transition Issues During SNF Closure: The transition of patients to a new service or facility during closure was not identified as a problem by study participants. When possible, CAHs worked with local nursing homes to facilitate the transfer of patients to alternative services. In one case, the hospital was able to sell its beds to a local nursing home that needed beds to meet local demand. The sale and transition of beds was relatively straightforward given that they remained in service in the county. The respondent noted that the sale of beds would likely have been more difficult from a regulatory/Certificate of Need basis if they were moved out of the county or taken out of service. Study hospitals used their swing beds to aid in the transition.

Community Acceptance/Involvement in Decision to Close SNF Unit: Although some respondents noted initial negative reactions to the news that the SNF was closing, community concerns generally dissipated once citizens were informed of other community alternatives. On the whole, respondents reported relatively little negative response from the community regarding their decisions to close their units. A few reported that they held community meetings to explain their decision to close a SNF unit. Others reported working closely with their boards/governing bodies prior to finalizing the decision to close. One respondent noted some initial community concern regarding SNF closure that later dissipated as patients and community members experienced no loss in access. Another said that members of the community “freaked out” when they heard about the closure but noted that the hospital used community meetings, open meetings with the board, and local interviews to reassure residents that services would be available through its swing and custodial beds. A few stated that some of their patients preferred the use of swing beds for SNF and LTC over the alternate local resources given their perception of greater levels of service and capacity in the hospital.

Physician and Staffing Issues Following the Closure Decision: Somewhat surprisingly, none of the respondents noted physician or staff opposition to their SNF unit closure. In one instance, an administrator explained that availability of LTC services within a reasonable distance was a factor in physician support of the closure as they could continue to follow their patients in the nursing home. In at least one case, the lack of staff resistance was due to the fact that SNF staff were hired by the facility that acquired the SNF beds. The limited personnel pool for health care workers in other instances made it easier for personnel to find positions with other LTC services.

Use of Swing Beds Following Closure: Although some respondents describe the use of swing beds as a substitute for SNF beds following closure, this was not always the case. In other instances, respondents described the use of swing beds for rehabilitative services following an inpatient stay at the CAH or another hospital or for complex patients requiring intravenous antibiotics or other therapies. Others suggested that swing beds were used primarily for patients requiring shorter stay courses of care prior to being discharged to a nursing facility or their home. These findings were consistent with those reported by Freeman and Radford¹² in their study of swing bed use by CAHs and PPS hospitals. In their study, CAHs and other rural hospitals reported using their swing beds for patients requiring rehabilitation and therapy care, intravenous antibiotics, wound care, and other health problems typically seen in elderly patient populations. Hospital administrators in their study reported that they were more likely to care for more complex patients in their swing beds than in local SNFs. They were also more likely to admit patients requiring relatively short-term stays to their swing beds and to seek other care options for those patients requiring longer term care.

Given the reported census levels of their SNF units prior to closure and acute care census levels at less than full capacity, it seems surprising that respondents did not report higher swing bed utilization. It is not possible, however, to determine if this apparent unused swing bed capacity represents a potential opportunity to improve hospital revenues by providing needed SNF and LTC services. Similar to our study, Freeman and Radford¹² found that CAHs and other rural hospitals maintained relatively low swing bed average daily censuses (an average of two swing bed patients per day) even though swing beds had a positive financial impact for their hospitals.

Continued SNF Operation Findings

Factors Influencing Continued SNF Operation: Community need was the most common reason offered for the continued operation of a SNF unit, notwithstanding the financial disincentives for providing SNF services. SNF services at the nine hospitals that retained their SNF units were located within existing hospital-based intermediate care nursing home units on the hospital campus. Most hospitals provided services in dually certified beds. As a result, they provided LTC services to a range of Medicare, Medicaid, and private pay patients. Somewhat surprisingly, the need for the use of SNF beds to manage acute inpatient census and length of stay issues was not identified by any of our nine respondents as a factor influencing the continued operation of their SNF services.

Four respondents noted that they were the primary source of SNF and other LTC services in the community. Access to the next closest SNF provider typically required a drive of 15 or more miles. Overall, the respondents described their SNF/intermediate level services as important components of their hospital's continuum of care.

Operation of SNF Services Within the Continuum of Hospital-Provided LTC Services: The nine hospitals that continue to provide SNF-level care described SNF/LTC units ranging from 36 to 69 beds with three reporting declines in the overall number of SNF/LTC beds due to profitability issues or state Medicaid policy changes. One respondent explained that his hospital maintained the same number of LTC beds but decertified 37 of its 42 dually certified SNF/intermediate care beds. Five dually certified beds were retained to provide SNF/intermediate care services.

All of the nine hospitals reported they provide SNF, intermediate, swing bed, and custodial/residential services. The hospitals saw this service mix as a continuum of care with each ascending level treating a more complex array of patients and conditions. Most described the use of swing beds for the most complex post-acute care patients requiring therapy, rehabilitative services, or intravenous medications, with the SNF and intermediate beds used for less complex patients. Unlike other respondents in our study and those interviewed by Freeman

and Radford,¹² one respondent stated that there was no difference in the types of patients and conditions treated in their SNF and swing beds.

A number of respondents reported relatively small declines in SNF/intermediate care utilization over time but noted that the numbers seemed to have stabilized. The majority of patients treated in these mixed units were typically longer-term intermediate care patients.

We heard few concerns about the rate of Medicare PPS reimbursement for SNF services from respondents in this group despite the fact that the financial impact on hospital reimbursement of operating a SNF unit was a commonly cited reason from closure among CAHs that had closed their SNF units. Medicaid reimbursement for SNF and other LTC services, however, was frequently described as poor or inadequate. As a result of inadequate Medicaid reimbursement, a number of respondents noted that their LTC services were not profitable. Private/self payments for SNF, swing bed, and other LTC are an important source of revenue for these hospitals. Other respondents noted that they tried to reserve beds for Medicare and private pay patients to avoid an excess Medicaid payer mix. One respondent noted that they had 10 to 12 private pay patients in their 45 bed SNF/intermediate care unit. Others explained that higher levels of payment from private pay patients helped to reduce the financial losses of their units.

Challenges to the Continued Operation of SNF Services: Low reimbursement rates, particularly from Medicaid, were identified as a major barrier to the continued operation of SNF/LTC services by study participants. Despite this, relatively few respondents reported that their hospital's leadership was considering closing the service. Several noted that the issue had been discussed and then rejected due to local need.

A number of these facilities reported difficulty recruiting and retaining appropriately trained staff. Several noted challenges with regulatory issues, such as the need for additional certification surveys for the SNF/LTC services. Two noted the challenge and expense of maintaining and upgrading the facilities to meet patient and family expectations, particularly regarding the desire for private rather than shared rooms.

A number of respondents noted difficulties serving certain types of patients including those with mental health, dementia, and other cognitive problems; "difficult" patients who had trouble getting along with their roommates; violent or aggressive patients; and patients with more complex needs such as those on ventilators. These types of patients often require placement in facilities in larger cities that are distant from the hospital.

Only a few reported problems with waiting lists or an inability to accept routine patients due to census levels, and these tended to be episodic occurrences. When occupancy problems arise, the hospitals refer the patient to other local LTC services or less commonly to facilities in more distance communities.

Limitations

Because this study is based on a very small sample of CAHs, the results cannot be generalized to all CAHs. Nevertheless, the study provides insights into the factors that have contributed to decisions by CAHs to retain or close their SNF units and the potential implications of closures.

Conclusions and Discussion

CAHs are an important, and sometimes the only, source of SNF and other LTC services in rural communities. However, the closure of hospital-based SNF units does not seem to have had a significant negative impact on access to needed SNF and LTC services, as swing beds and alternative community service providers appear to have filled the gap.

One of the more interesting findings in this study is the variation in the use of swing beds across the study hospitals for SNF, rehab, and post-acute services. Although this is a very limited look at the SNF activities of a small subset of CAHs in 11 states, the findings suggest that further study is warranted to more fully understand the role of swing beds in rural systems of care. Our observations and discussion of the need for additional study of the role of swing beds in rural systems of care are supported by Reiter and Freeman's¹³ examination of SNF and swing bed use following the Medicare Modernization Act of 2003 and Freeman and Radford's¹² interviews with hospital administrators and staff on swing bed use. Reiter and Freeman¹⁴ found an increase in the number of swing beds days reported by CAHs consistent with the increase in the number of CAHs, but only minor changes in the average daily census for swing bed care in CAHs located in the most rural areas. Freeman and Radford¹² found that hospital respondents reported different philosophies in the use of swing beds with some reporting that they were more likely to use swing beds only for patients requiring relatively short lengths of stay (i.e., one to two weeks).

Additional findings also suggest that further study is warranted on whether or not a more consistent approach to the use of swing beds represents an opportunity for CAHs to improve their service capacity and ability to generate patient care revenues. Again, the findings are supported by previous research. Although Reiter and colleagues at the North Carolina Rural Health Research and Policy Analysis Center estimated the cost to Medicare of a SNF-type swing bed day (\$583) in a CAH to be roughly half of the average per-diem reimbursement, they noted that elimination of Medicare swing bed days would put financial pressure on CAHs and reduce

access to post-acute skilled care for rural Medicare beneficiaries.¹³ Given the ongoing concerns about financial viability and low census rates among some CAHs, an exploration of the ability of CAHs to expand patient services and revenues by meeting community needs through consistent swing bed use seems particularly timely.

It is also interesting and important that CAHs that continue to operate SNF and other LTC services commonly report that the services are not profitable. This suggests the need for further study to better understand the reasons for this lack of profitability and to identify opportunities to enhance the financial performance of these important rural services.

One additional area that warrants further study is the quality of care provided in CAH-based SNF units and swing beds. We were unable to find any current studies describing the quality of SNF and other long term care services in CAHs. Given the important role of CAHs in providing SNF and other long term care services in rural communities, further study is needed to understand the quality of care provided and any potential differences in quality and health outcomes for care provided in SNF and swing beds.

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APPENDICES

Appendix 1: Key Study Terms

Appendix 2: Methodology

Appendix 3: CAHs that closed their SNF units during the period 2004-2007

Appendix 4: CAHs that continued to operate their SNF units during the period
2004-2007

Appendix 5: Protocol for CAHS that closed a hospital-based SNF Unit

Appendix 6: Protocols for CAHs operating hospital-based SNF units

Appendix 1: Key Study Terms

<i>Long Term Care Services</i>	<i>Definitions</i>
Skilled nursing (SNF)	Non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis. Primarily reimbursed by Medicare.
Intermediate care (ICF)	Health-related services (skilled nursing care and social services) provided to patients with physical conditions or functional disabilities that do not require the care provided by a hospital or skilled nursing facility, but do need supervision and support services. Primarily reimbursed by Medicaid.
Other long term care (LTC)	Long term care other than skilled nursing care or intermediate care including residential care-elderly housing services for those who do not require daily medical or nursing services, but may require some assistance in the activities of daily living, or sheltered care facilities for the developmentally disabled.
Assisted living	Combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help in activities of daily living and instrumental activities of daily living.
Home health services	Nursing, therapy, and health-related homemaker or social services provided in the patient's home.
Retirement housing	Housing and social activities to senior citizens, usually retired persons, who do not require health care but may require some short-term skilled nursing care.
Swing bed services	A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. Available only to hospitals with a Medicare provider agreement in place, fewer than 100 beds, located in a rural area, without a 24 hour nursing service waiver in effect, not been terminated from the program in the prior two years, and meeting various service conditions.

Appendix 2: Methodology

Medicare Cost Report data for the period 2004-2007 were used to identify the population of CAHs offering SNF level services in 2004 and any changes in the provision of those services by CAHs in subsequent years. Using these data, we identified 20 states with at least one CAH that had closed a SNF unit since 2004 and one CAH that continued to operate a SNF. We selected a convenience sample of 30 hospitals reflecting geographic diversity and differing ownership types (i.e., non-profit and government owned). We completed 20 interviews in 11 states. Eleven interviews were conducted with CAHs that had closed their SNF units and nine with CAHs that continued to operate SNF services. Five of the CAHs with closed SNF units were government owned and six were non-profit (501c3) hospitals. Of those CAHs operating SNF units, one was government owned and the remaining eight were non-profit.

As our study is based on a convenience sample of 30 CAHs, our findings are not generalizable across the full populations of CAHs. They do however, provide insight into the factors and issues related to the operation of SNF services by CAHs and the complex interplay between the conflicting incentives provided by cost-based and PPS reimbursement for services in CAHs.

Qualitative interviews were conducted by telephone during the summer and fall of 2011 using semi-structured interview protocols. Interview respondents included Chief Executive Officers, Chief Operating Officers, Directors of Nursing, and Directors of Long Term Care Services. The protocols were designed to collect information on each CAH's decision to either close or continue to operate its SNF unit as well as information on the available SNF and other LTC services in the community. For CAHs that closed their SNF units, we collected information on factors driving closure decisions and the impact of closure on the hospital, patients, and the community. For those operating SNF units, we collected information on the history and operation of the unit and the impact of the unit on the hospital's financial performance (See Appendixes 3 and 4).

Appendix 3: CAHs that Closed Their SNF Units During the Period 2004-2007

Hospital Name	Town, State	Rurality*	Bed Size	Ownership	System Involvement
Davis County Hospital	Bloomfield, IA	Isolated Rural	25	County Owned	Mercy Health Network
Edgerton Hospital	Edgerton, WI	Urban	25	Tax Exempt	
Fort Logan Hospital	Stanford, KY	Small Rural	25	Tax Exempt	Ephraim McDowell Health
IU Health/ Tipton Memorial Hospital	Tipton, IN	Small Rural	22	Tax Exempt	Indiana University Health
Morton General Hospital	Morton, WA	Isolated Rural	25	Hospital District/ Authority	
Penobscot Valley Hospital	Lincoln, ME	Isolated Rural	25	Tax Exempt	
Perry Memorial Hospital	Princeton, IL	Small Rural	22	City Owned	
Providence Seaside Hospital	Seaside, OR	Small Rural	25	Tax Exempt	Providence Health & Service
Riverwood Healthcare Center	Aitkin, MN	Isolated Rural	20	Tax Exempt	Northern Healthcare Partnership
Saint Luke's Hospital	Columbus, NC	Isolated Rural	19	Tax Exempt	Western North Carolina Health Network
Wheatland Memorial Hospital	Harlowton, MT	Isolated Rural	25	County Owned	

* Based on the 2000 Rural Urban Commuting Area Codes developed by the WWAMI Rural Health Research Center

Appendix 4: CAHs that Continued to Operate Their SNF Units During the Period 2004-2007

Hospital Name	Town, State	Rurality*	Bed Size	Ownership/ Control	System Involvement
Chippewa Valley Hospital	Durand, WI	Isolated Rural	25	Church Operated/ Tax Exempt	
Gibson Area Hospital and Health Services	Gibson City, IL	Small Rural	25	Tax Exempt	
Gibson General Hospital	Princeton, IN	Small Rural	25	Tax Exempt	
Lakewood Health Center	Baudette, MN	Isolated	15	Church Operated Tax Exempt	Catholic Health Initiatives
North Valley Hospital District	Tonasket, WA	Isolated Rural	25	Hospital District/Authority	
Pondera Medical Clinic	Conrad, MT	Small Rural	20	Tax Exempt	
Rusk County Memorial Hospital	Ladysmith, WI	Small Rural	25	County Owned	
St. Andrews Hospital	Boothbay Harbor, ME	Isolated Rural	19	Tax Exempt	MaineHealth
Sioux Center Community Hospital	Sioux Center, IA	Small Rural	21	Tax Exempt	Avera Health

** Based on the 2000 Rural Urban Commuting Area Codes developed by the WWAMI Rural Health Research Center*

Appendix 5: Protocol for CAHS that closed a hospital-based SNF Unit

History of SNF unit

1. How long did your hospital operate its SNF unit?
2. When was the unit closed?
 - a. How many SNF beds did your hospital operate? What was a typical occupancy rate? Average length of stay (ALOS)?
3. How did SNF services fit into the context of your hospital's primary mission?
4. In the year prior to closure, how was the unit performing financially?
5. Does your hospital offer other long term care services and, if so, what services?

Closure of SNF Unit

6. Why did the hospital decide to close the unit?
7. Are there any other reasons for the closure?
8. What problems, if any, did the hospital face in closing the SNF unit? (Probes: community sentiment/resistance, Certificate of Need requirements, etc.)?

Impact of SNF Unit Closure

9. What impact, if any, did the closure have on your hospital's patients?
10. Are patients able to access other SNF services in your community in a timely fashion? Are there access issues for SNF services?
11. Do you have formal agreement(s) with available SNFs for patient discharge?
12. Does access to SNF services vary by complexity of patient needs? If there are barriers, what are the alternatives for patients needing SNF care?
13. If SNF services are not available locally, how far must patients travel to access SNF services? Are these services accessible in a timely fashion?
14. How does your staff handle discharges for patients needing but unable to access SNF services? Does this differ across patient types based on complexity of needs?
15. What was the impact of the SNF unit closure on your hospital operations and staff?
16. How would you describe the impact of the closure on the community?

Community Context

17. Please describe the long term care services available in your community (not offered by the hospital)? Please identify all that are available.
18. What services are not available locally? What is the nearest service?
19. How easily can patients move across the long term care system within your community (e.g. from assisted living to SNF/NF care)? Are there challenges to accessing LTC services? (Probes: Waiting lists? Payment issues? Other barriers?)

Appendix 6: Protocols for CAHs operating hospital-based SNF units

History of SNF unit and LTC services at hospital

1. How long has your hospital operated its SNF unit?
2. How many SNF beds does your hospital operate? Average occupancy rate? Average length of stay? (Any changes in these trends?)
3. Does your hospital operate swing beds? If yes, is your average daily swing bed census and average swing bed length of stay?
 - a. Does your hospital's use of swing beds differ from SNF beds (e.g., different patient populations, different conditions, etc)?
4. How does the SNF unit fit into your continuum of services?
5. Are there other SNF units in your community?
6. How do SNF services fit into the context of your hospital's primary mission?
7. How would you describe the financial performance of your SNF?
8. Have you ever considered closing the SNF unit? If so, why did you consider closure?
9. Why do you continue to operate the SNF unit (acute care census management issues, local needs, community resistance, Certificate of Need issues, etc.)?

Operation of SNF Unit

10. What are the major challenges to the continued operation of your hospital's SNF unit?
11. What factors support your hospital's continued operation of its SNF unit?
12. Are you ever forced to refuse a referral to your SNF unit? If so, how often does this happen and why.
13. If yes, how are these patients handled?

Community Context

14. Does your hospital offer other long term care services? If so, what services? (Probes: Nursing home/facility services, residential services (e.g., assisted living or congregate care housing), home health services, other services?)
15. Please describe the long term care services available in your community (not offered by the hospital)? Please identify all that are available.
16. What, if any, key services are not available? How far do patients have to travel to access these services?

List of Acronyms

BBA	Balanced Budget Act
CAH	Critical Access Hospital
LTC	Long Term Care
MedPAC	Medicare Payment Advisory Commission
PPS	Prospective Payment System
SNF	Skilled Nursing Facility